THE SECRETARY OF VETERANS AFFAIRS

WASHINGTON

October 18, 2004

The Honorable Lane Evans
Ranking Democratic Member
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Evans:

I am pleased to furnish the fourth annual report of the Department of Veterans Affairs (VA) Special Committee on Post-Traumatic Stress Disorder (PTSD). This report is provided in accordance with section 110 of Public Law 98-528, as amended by section 206 of Public Law 106-117.

This report consists of the 2004 Report of the Department of Veterans Affairs (VA) Special Committee on PTSD, and the Under Secretary for Health responses to the Committee's recommendations. These two documents address VA's clinical care, educational and research efforts in treating PTSD. The report also provides a complete listing of Vet Centers by location, along with an inventory of specialized PTSD programs offered at VA medical facilities. The Committee has compiled prior recommendations into measurable objectives and current PTSD research projects. They are included as attachments to the report.

The actions recommended in this report will enable VA to meet the present challenge and prepare VA for the future needs of existing veterans and new veterans from the Global War on Terrorism.

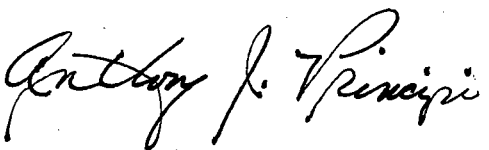
The Under Secretary for Health's responses were drafted prior to the release and approval of the Mental Health Strategic Plan (MHSP). Therefore, the Chief Consultant for the Mental Health Strategic Healthcare Group contacted the Chairmen of the Special Committee on Post-Traumatic Stress Disorder (PTSD) to review the MHSP and its implications for the Committee's recommendations and the Under Secretary for Health's responses. Five recommendations are included in the MHSP, and implementation strategies for those five will be consistent with the Under Secretary for Health's responses. Two recommendations, (1) to identify a PTSD coordinator with each Veterans Integrated Service Network and Readjustment Counseling Services Region, and 2) to support the National Vietnam Veterans Longitudinal Study) are not in the MHSP, but are directly addressed and supported by the Under Secretary for Health in his response to the Committee.

As required by the Veterans Benefits and Health Care Improvement Act of 2000, Public Law 106-419, a statement of the cost of preparing this report is enclosed.

The Honorable Lane Evans

The Department looks forward to continuing to work with you in ensuring access and improving PTSD health care for our Nation's veterans. Similar letters have been sent to other members of the House and Senate Committees on Veterans' Affairs. Should your staff have comments or questions, please have them contact Dr. Mark E. Shelhorse, Acting Chief Consultant, Mental Health Strategic Health Care Group, at (202) 273-8434.

Sincerely yours,



Anthony J. Principi

Enclosures

Fourth Annual Report of the Department of Veterans Affairs

Under Secretary for Health's Special Committee

On

Post-traumatic Stress Disorder: 2004

Under Secretary for Health's
Special Committee
On
Post-traumatic Stress Disorder

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Fourth Annual Report of the Under Secretary for Health's Special Committee on Post-Traumatic Stress Disorder

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Executive Summary

The statutory charge to this Special Committee, laid out in section 110 of Public Law (PL) 98-528 (1984), as amended by section 206 of PL 106-117, the Veterans Millennium Health Care and Benefits Act, is to determine the Department of Veterans Affairs' (VA's) capacity to provide assessment and treatment for Post-traumatic Stress Disorder (PTSD), and to guide VA's educational, research and benefits activities with regard to PTSD. Section 405 of PL 108-170 has extended the reporting activities of the Committee through 2008. The Special Committee is composed of PTSD experts from across a broad spectrum of VA's Mental Health and Readjustment Counseling Services (RCS).

When the Special Committee first met in December 2000, the nation had been at peace for several years. We therefore developed specific recommendations and measurable objectives designed to meet the needs of veterans of past wars. While VA remains dedicated to caring for veterans of past wars, the terrorist attacks of September 11, 2001 and ongoing military operations in Afghanistan and Iraq have forced us to recognize that VA cannot afford a vision that is primarily *retrospective*. VA must prepare to meet the needs of a new generation of combat veterans, many of whom are still in uniform as of this writing. This requires a *prospective* approach to post deployment mental health including the earliest possible identification and treatment of posttraumatic readjustment problems and, whenever possible, the prevention of chronic PTSD. The challenge is clear, great, and already upon us.

Combat veterans of Operations Enduring Freedom (OEF) and Iraqi Freedom (OIF) are at high risk for PTSD and related problems. The Army's OIF Mental Health Advisory Team Report documents that 15.2 percent of American soldiers in Iraq screen positive for traumatic stress. The suicide rate for soldiers in Iraq is higher than the Army's base rate and higher than rates during the Gulf or Vietnam Wars. An estimated 40 percent of OEF/OIF casualties returning by way of Walter Reed Army Medical Center report symptoms consistent with PTSD. Twenty percent of over 6000 OEF/OIF veterans who have already contacted Vet Centers report symptoms of psychological trauma.

VA needs to proceed with a broad understanding of post-deployment mental health issues. These include major depression, alcohol abuse (often beginning as an effort to sleep), narcotic addiction (often beginning with pain medication for combat injuries), job loss, family dissolution, homelessness, violence towards self and others, and incarceration. It may be possible to prevent or ameliorate these if decisive action is taken now.

Action begins with integration of services. Rather than set up an endless maze of specialty programs, each geared to a separate diagnosis and facility, VA needs to create a progressive system of engagement and care that meets veterans and their families where they live. It must strengthen the Department of

Defense (DoD)/VA continuum of care including primary care and mental health programs as well as benefit services through Veterans Benefits Administration (VBA). The emphasis should be on wellness rather than pathology; on training rather than treatment. The bottom line is prevention and, when necessary, recovery. These principles are consistent with military medical doctrine and central to the recommendations of the President's New Freedom Commission on Mental Health.

A number of initiatives have already been undertaken across DoD and VA. In approaching this population, it is important to recognize that new combat veterans (including Guard and Reserve members) come to VA by a number of different pathways. Intervention plans specific to each group are outlined in this report. Each recommended element would engage new combat veterans and their families at different points in the DoD/VA continuum and each would serve to facilitate and strengthen that continuum.

VA must meet the needs of new combat veterans while still providing for veterans of past wars. Unfortunately, VA does not have sufficient capacity to do this. VA PTSD services had been steadily losing capacity even before OEF/OIF began.

If the human cost of PTSD and its related disorders is staggering, so are the long term medical costs to VA associated with chronic PTSD. VA must act now to engage a new generation of combat veterans and their families early and proactively in order to prevent or ameliorate chronic PTSD and its related post deployment disorders whenever possible. The potential cost offsets, human and financial, far outweigh the investment required.

In order to maintain a sharp focus and a clear agenda, the Committee has closed out as many of our original 37 recommendations as possible (see Attachment A) and realigned the remaining recommendations with the three core priorities and their linked actions as laid out in our 2003 report:

1. *Provide the range and intensity of specialized programs necessary to meet the service-related needs of veterans with PTSD*
   Required Actions:
   A. Establish a PTSD Clinical Team (PCT) at every VA medical center
   B. Locate a family therapist within each Vet Center

2. *Promote best practices and evidence-based care for PTSD and other debilitating psychological responses to military trauma*
   Required Actions:
   A. Convene a National Education Steering Committee: The Joint DoD/VA Council on Post Deployment Mental Health
   B. Identify a PTSD Coordinator within each Veteran Integrated Service Network (VISN) and Readjustment Counseling Service (RCS)

region and, in coordination with VA Central Office (VACO), convene them as a National PTSD Continuity Committee

3. *Ensure VA's readiness to respond to the mental health consequences of combat, terrorism, and incidents of mass violence by supporting programs that are essential to its PTSD mission*
   Required Actions:
   A. Support VA's National Center for PTSD
   B. Support the National Vietnam Veterans Longitudinal Study (NVVLS)
   C. Identify PTSD as a VA Research Priority

The actions recommended in this report will enable VA to meet the present challenge and prepare for future challenges. The prospective stance and new focus on the larger spectrum of post deployment mental health diagnoses and functional problems advocated here will transform VA's PTSD programs and vastly increase their relevance and efficacy. In times of peace, VA can keep its post deployment skills sharp by responding to veterans of past deployments, Military Sexual Trauma (MST), workplace violence, and local, regional, and national disasters. Although it has taken a new war to force a paradigm shift, it is clear that this action has long been needed across the DoD/VA continuum.

Fourth Annual Report of the Under Secretary for Health's Special Committee on Post-Traumatic Stress Disorder

Introduction

The statutory charge to this Special Committee, laid out in section 110 of PL 98-528 (1984), as amended by section 206 of PL 106-117, the Veterans Millennium Health Care and Benefits Act, is to determine the Department of Veterans Affairs' (VA's) capacity to provide assessment and treatment for PTSD, and to guide VA's educational, research and benefits activities with regard to PTSD. Section 405 of PL 108-170 has extended the reporting activities of the Committee through 2008. The Special Committee is composed of PTSD experts from across a broad spectrum of VA's Mental Health and RCS.

At the time of the Special Committee's first meeting in December 2000, the nation had been at peace for several years. The Committee therefore developed specific recommendations and measurable objectives designed to meet the needs of veterans of past wars. The 37 recommendations made at that time have guided our efforts since. A spreadsheet documenting progress to date on those original recommendations is attached as Attachment A of this report.

While VA remains dedicated to caring for veterans of past wars, the terrorist attacks of September 11, 2001 and ongoing military operations in Afghanistan and Iraq have forced us to recognize that VA cannot afford a vision that is primarily *retrospective*. In 2004, VA must prepare to meet the needs of a new generation of combat veterans, many of whom are still in uniform as of this writing. This requires that VA adopt a new *prospective* approach to post deployment mental health including the earliest possible identification and treatment of posttraumatic readjustment problems and, whenever possible, the prevention of chronic PTSD. The challenge is clear, great, and already upon us.

VA is a world leader in PTSD research and treatment. Past experience predicts that this new generation of combat veterans is at high risk for PTSD and other related post-traumatic disorders. One of every five casualties of World War II was psychiatric. The Congressionally commissioned National Vietnam Veterans Readjustment Study (NVVRS) demonstrated that one of three combat veterans suffered from PTSD at some point after that war and that half of those who ever had PTSD still had PTSD more than a decade later (Kulka, 1990). Large-scale epidemiologic research documents that 10 percent of all veterans of Operation Desert Storm currently have PTSD (Kang, Natelson, Mahan, et al., 2003) and this rises to 20 percent among those who were in heavy combat. Our troops in Afghanistan and Iraq are now taking part in a protracted military mission that combines many of the stressors encountered in previous wars. These include witnessing the effects of massive aerial bombardments, fighting an intensive ground war, withstanding incessant and ruthless attacks by an enemy that is not easily differentiated from the innocent civilians surrounding them, exposure to the

horrific results of those attacks, and surviving the daily challenges of a harsh, foreign environment.

Preliminary findings demonstrate that combat veterans of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) are at significant risk for mental health problems. The Army's recently released Operation Iraqi Freedom Mental Health Advisory Team Report (dated December 16, 2003) summarized a study of 756 soldiers serving in Iraq, 82 percent of who had engaged in battle. Twenty-three percent of OIF soldiers reported suffering from moderate to severe stress or from a moderate to severe emotional or family problem. Additionally, 6.9 percent screened positive for depression, 7.3 percent for generalized anxiety, and 15.2 percent for traumatic stress. Overall, 15 percent of all soldiers reported interest in receiving mental health services. Of those who wanted help, only about one-third received any assistance. Of special note, almost half of all soldiers surveyed reported not knowing how to access mental health services and those who expressed a desire to seek mental health assistance perceived barriers to receiving that assistance. The suicide rate for soldiers deployed to OIF between January and October 2003 was 15.6 per 100,000. This is considerably higher than the Army's base suicide rate over the previous eight years (11.9/100,000) and higher than rates reported during the Gulf or Vietnam Wars.

On February 18, 2004, United Press International reported that 10 percent of soldiers evacuated through the military medical center at Landstuhl, Germany (the primary route for medically evacuated from OEF/OIF) had "psychiatric or behavioral health issues." On February 19, 2004, the *Washington Post* reported that nearly 600 Army soldiers from Iraq had been sent to mental health treatment facilities. On February 12, 2004, VA's Office of Public Health and Environmental Hazards reported, based on information provided by the Department of Defense (DoD), that over 13,000 Iraqi Freedom veterans and nearly 1,800 Enduring Freedom veterans had already presented to VA Medical Centers for a variety of health concerns. Based on the latest RCS data at the time of this writing, over 6,000 OEF/OIF veterans have already contacted Vet Centers. Of these 6,000, 20 percent report symptoms consistent with psychological trauma. The Army's Deployment Health Center at Walter Reed Army Medical Center has determined that, at 3 month follow up, 40 percent of all casualties of Afghanistan and Iraq hospitalized at Walter Reed (including the medical and surgical casualties) reported symptoms consistent with a diagnosis of PTSD (personal communication, October 17, 2003).

As with other medical disorders, the complications of traumatic stress are often as prevalent, severe and persistent as PTSD, itself. These include major depression, alcohol abuse (often beginning as an effort to sleep), narcotic addiction (often beginning with pain medication for combat injuries), job loss, family dissolution, homelessness, violence towards self and others, and

incarceration. It may be possible to prevent these complications if decisive action is taken now.

Taking Action

Action must begin with integration of services. Rather than set up an endless maze of specialty programs, each geared to a separate diagnosis and facility, VA needs to create a progressive system of engagement and care. This program must be centered on the patient and his/her family and it must step up to meet prospective users where they live rather than wait for them to find their way to the right mix of services. It must concentrate on strengthening the DoD/VA continuum of care including primary care and mental health programs as well as benefit services through Veterans Benefits Administration (VBA). This will require DoD and VA to break out of their silos in order to provide informed, flexible responses that follow people as they move from one system to the next.

VA must ensure that PTSD resources are strong in DoD and VA but we cannot expect to channel every returning veteran through subspecialty PTSD services. The concept of PTSD is valid and essential but it is too narrow a lens with which to view the big picture before us. Some patients will only have transient acute stress reactions; others will develop chronic depression or substance abuse or functional problems that would not be addressed were we to focus all resources on PTSD alone. VA needs to proceed with a broad understanding of post-deployment mental health issues.

One of these is Military Sexual Trauma (MST). Dr. Jessica Wolfe of the National Center for PTSD (NC-PTSD) reported (1998) that 7.3 percent of female Gulf War Veterans reported attempted or completed sexual assault during deployment. The US Army has released statistics indicating that 26 women reported rape or other sexual abuse during the first Gulf War. It is important to remember that only about 16 percent of rapes are ever reported. It is also important to realize that the number of male veterans who have reported sexual trauma during military service is roughly equal to the number of female veterans reporting MST. This is because of the preponderance of men in the armed forces (20:1). The *New York Times* reported on February 26, 2004, that there have already been 112 reports of sexual misconduct over the past 18 months in the Central Command area of operations, which includes Kuwait, Afghanistan, and Iraq. As we bring service men and women home, we must screen for the effects of MST and be ready to provide treatment when it is needed.

Suicide is another concern during and after deployment. As noted above, DoD has already documented an increased rate of suicide among American troops serving in Iraq. This does not include suicides among those who have already returned home. Two soldiers have committed suicide at Walter Reed post deployment and other suicides have been reported among returning combat

veterans. Based on clinical experience, it is reasonable to assume that this risk will persist unless intervention is made early and continued over time.

Marital discord and domestic violence have often been associated with post deployment mental distress. In the wake of deployment to Afghanistan, four Ft. Bragg spouses were killed by their husbands. Family support before, during, and after deployment are critical elements of a post deployment mental health plan.

While the scientific literature on the efficacy of early intervention is still in its infancy, a growing body of research strongly supports longstanding clinical emphasis on identifying problems early and intervening decisively (Watson, 2003). These principles of intervention are laid out in the recently released Joint VA/DoD Clinical Practice Guideline for the Management of Traumatic Stress (CPG: available at http://www.oqp.med.va.gov/cpg/PTSD/PTSD_Base.htm). These, in turn, reflect time-tested elements of military doctrine: treat survivors of combat stress with immediacy and with high expectation of recovery.

In creating an early intervention program in the context of our current situation, the emphasis must be on wellness rather than pathology; on training rather than treatment. The bottom line is prevention and, when necessary, recovery. These same principles are central to the recommendations of the President's New Freedom Commission on Mental Health (2003) which describe the recovery model as care that focuses on increasing a person's ability to successfully cope with life's challenges, not just on managing symptoms. Recovery is accomplished in partnership with combat veterans and their families. The recovery model has two key advantages: (1) it invites veterans and their families to take an active role in adapting to post deployment issues. Passivity is a key element of psychological trauma. Emphasis on active coping is of particular importance in recovery from traumatic events; (2) the focus of recovery is on solving problems rather than on being ill. Experience in VA demonstrates that many veterans can live a full life despite PTSD if they can be helped to cope with their ongoing symptoms and to maintain their families and jobs.

A number of initiatives have already been undertaken across DoD and VA. The Special Committee on PTSD has reviewed these plans with representatives of VA and DoD Mental Health, Primary Care and Chaplaincy programs (including Guard and Reserve programs) as well as with VHA's Readjustment Counseling Service, Women's Health, VBA, and the Seamless Transition Task Force. These, together, constitute a rich array of services but there is a pressing need for greater integration. In approaching this population, it is important to recognize that new combat veterans (including Guard and Reserve) come to VA by a number of different pathways including those who return as casualties and those who return by way of military demobilization sites. Each will have different needs and will each require a different engagement strategy.

Reaching out to Combat Casualties

A relatively simple intervention that builds on current practices could significantly improve mental health outcomes among combat casualties. New combat veterans who return to the United States for medical reasons enter the VA system by way of Military Treatment Facilities (MTFs) including Brooke, Eisenhower and Walter Reed Army Medical Centers and the National Naval Medical Center at Bethesda. VA is currently collaborating with DoD in the transfer of returning combat veterans from MTFs to VA care. VA social workers serve as VHA/DoD Liaisons to provide an interface between VA and DoD at the MTFs as part of the Seamless Transition Plan. VA has also identified a Point of Contact (POC) staff person and a case manager for OEF/OIF veterans at every VA Medical Center.

Most POCs are social workers who, by virtue of their professional training, are particularly good at the kind of interventions needed when a new patient first makes contact with VA yet few POCs or case managers have been trained to recognize or manage traumatic stress disorders in new combat veterans. It would be an easy matter to define a brief curriculum for the POCs and case managers that would alert them to signs of traumatic stress, its complications, and its effects on patients and their families. Most of the necessary teaching materials are already available in the Iraq War Clinician Guide, which has been prepared and disseminated by the National Center for PTSD in partnership with the Uniform Services University of the Health Sciences (available at the National Center for PTSD website: www.ncptsd.org). It would not be necessary to make each POC and case manager a mental health specialist. It would suffice to prepare them to spot a problem and know when and how to triage.

The second aspect of this training would be to educate the POCs and case managers about the resources to which these new veterans and their families can be triaged. This would provide exceptional coverage for new combat veterans in the Seamless Transition process.

Note that VBA has detailed a benefits counselor to each MTF and benefits POCs at every VA Regional Office (VARO). They work side by side with DoD staff and the VHA/DoD Liaisons to facilitate the transition of new combat veterans and their families to VA programs and processes. These VBA staff should also be included in post deployment mental health training because their ability to spot and appropriately refer a veteran with a post deployment mental health problem could have important consequences in terms of that veteran's future access to care and benefits.

Reaching Out to Combat Veterans Returning Via Demobilization Sites

A more formidable challenge exists in addressing the needs of the majority of returning troops as they arrive home by way of demobilization sites at military

bases across the country. Many of these men and women will remain in active service and are not about to be triaged to VA. Guard and Reserve members also return home by way of demobilization sites but then abruptly find themselves back in their communities rather than on military bases where they and their families would have greater access to DoD mental health services and where they might receive more social support from their community (Guard and Reserve members might be the only one at their job site who has just come back from a war; their spouses may also be alone in their situation and their children may be the only ones in their class or school who had a deployed parent. At least in military communities there is a greater understanding of these issues in schools, businesses, churches and other local institutions).

During demobilization, every returning service man and woman completes the Post Deployment Evaluation Screen (Form 2796). This screening process is well established at MTFs but may be less uniform at demobilization sites. Although Post Deployment Evaluation Screen results include essential information about stressors and about signs of posttraumatic responses, they are not currently being made available to VA planners or clinicians. This must change. Taken in aggregate, post deployment data would provide an important early indicator of PTSD prevalence among our troops, which would enable planners to better identify and meet their needs. If each individual service man/woman's responses were available to his/her VA clinician at the time of presentation for services, the information would be of critical importance in developing an appropriate treatment plan.

Although it makes intuitive sense to include a formal Mental Health intervention during the acute demobilization process, it would probably not prove helpful. As one Army Medical Corps officer recently back from Afghanistan has said, returning soldiers don't have "the emotional bandwidth" to deal with those issues as yet. They are entirely focused on getting home and on the things they promised themselves and their loved ones. To insert an intervention during the demobilization process would be seen as coming between them and their going home. It would be more likely to lead to resentment and to greater stigmatization of the issue of psychological trauma.

Based on input from military experts and combat veterans of past wars, a better time to intervene would be after soldiers have had a chance to go home, sleep in their own beds, and spend time with their families. For many, returning home may be the best therapy in and of itself but others will find that they still can't sleep and that they remain jumpy and irritable. They may feel unable to cope with changes that happened while they were deployed. They may simply feel that they no longer fit. Some will predictably turn to substance abuse to "smooth over" tensions and sleep. The returning veteran's stress may be compounded by family stress as those around him/her worry about what they should do to help or feel guilty for having "failed" to be "good enough." Families may put pressure on the returning veteran to give up his/her military career in order to avoid future

deployments leaving the veteran trapped between loyalty to family and to his/her unit. In this way, post deployment stress spreads from individuals to their families, their units, and their communities.

After a few weeks at home, soldiers may be more likely to recognize any existing readjustment problems and may be better able to talk about them. In the Guard and Reserves, troops have 90 days of leave before they report again for weekend duty following deployment. The Special Committee suggests that 90 days be adopted as the standard period after which the post deployment mental health intervention would be made. Mental health professionals would best perform this because they have special skills in developing rapport and in recognizing psychological distress. We recommend that this intervention *not* be performed as a formal mental health examination but, instead, as routine post deployment *training*. Military personnel understand the importance of running a system check of their equipment following a mission. These meetings should be presented as routine maintenance for combat personnel.

The post deployment mental health intervention should be performed with individual service men/women or in small functional groups (platoon size at the most). It should begin with a "plain English" statement that people who have lived through combat have come to know things that other people may not understand. This places the returning service member in the position of being an expert as opposed to being a victim. The discussion would proceed to a review of difficulties commonly reported by combat veterans (which many people in the room will quickly recognize). It would offer ways to share experiences, thoughts and feelings with family and friends and lay out ways to anticipate and deal with common family concerns and tensions (soldiers are often hesitant to discuss their own responses but usually eager to talk about their family's worries).

Throughout the meeting, the emphasis would remain on normalizing responses to stressful experiences rather than on pathologizing them. This is an educational intervention based on principles of wellness and recovery, not an examination for purposes of diagnosis and determination of fitness for duty. The focus is on enhancing resilience. The basic orientation is that, even when there are readjustment problems, most people will be able to cope with them and that it is OK to get help if the combat veteran or his/her family is having trouble. Any disclosures about stressful experiences will be treated with respect but, unlike "debriefing" sessions, no one will be encouraged to relive traumatic memories in the course of the meeting. This is because research shows that people who undergo such debriefings may be at greater risk for developing PTSD. This may be because they were re-exposed to such memories before they were ready to deal with them (see the CPG for a detailed discussion of this issue).

Towards the end of the intervention, participants will be advised about the resources available to them and their families should any problems they are having persist or become worse. Participants will be assured of the

confidentiality of these sessions. No medical charts will be flagged and no one else will be brought into the process unless there is significant evidence of danger to self or others or unless the service man or woman specifically requests that such contact be made. A pamphlet will then be given which reinforces the information provided and identifies local resources along with specific contact names, websites, phone numbers, and a 1-800 call-in number (already established for the Army and soon to be implemented for all branches of DoD) for further confidential help. A separate pamphlet designed for the family will be mailed home.

The Co-Chairs of the VA PTSD and SMI Committees met with the Under Secretary for Health on March 1, 2004 to recommend that he work with DoD to develop a Memorandum Of Agreement (MOA) under which VA mental health staff would provide this intervention. This process is practical and likely to be well received by service men and women. If implemented, this early intervention has the potential to serve as a force multiplier in DoD settings and to improve health outcomes in VA settings.

VA and DoD could further extend their ability to offer post deployment counseling in a recovery model through the selection and training of peer counselors drawn from Military Unit Associations (Shay, 2002). Military Unit Associations have the distinct advantage of being local at each site and of already being a part of unit culture. Military Unit Association members also have the advantage of having "really been there" as combat veterans of past deployments. Their spouses could provide support and mentorship to the spouses of those who have been deployed. This is an opportunity to utilize a large, untapped resource of highly motivated and uniquely qualified mentors. Arrangements for their selection and training could also be included in the proposed MOA.

These proposed interventions would complement (and not compete with) the recently approved RCS outreach program, which is in the process of hiring 50 veterans of OEF/OIF in order to provide support and triage to services to service men and women and their families at the time of separation from service. Each recommended element of this progressive system of care would engage new combat veterans and their families at a different point in the DoD/VA continuum and each would serve to facilitate and strengthen that continuum.

Meeting the Ongoing Needs of Veterans of Past Deployments While Reaching Out to New Combat Veterans of OEF/OIF

VA must have the capacity to meet the needs of new combat veterans while still providing appropriate care for veterans of past deployments. Unfortunately, PTSD services are lacking in many VA medical centers and are severely limited at Community Based Outpatient Clinics (CBOCs). During the 1980's, the first Special Committee on PTSD urged development of a PTSD Clinical Team (PCT) at every VA medical center. Two decades later, only 86 of 163 VA medical

centers have PCTs. Many of the staff originally dedicated to PCTs have long since been drawn off to other duties or lost to attrition. The Committee on Care of Veterans with Serious Mental Illness has pointed out that some VISNs have failed to maintain capacity for PTSD treatment. The Office of the Inspector General has questioned whether 39 of the 86 PCTs actually have any staff assigned to them. The American Psychiatric Association (APA) echoed these concerns in their March 25, 2004 testimony to the House Appropriations Subcommittee on VA, HUD and Independent agencies. The Under Secretary for Health's Special Committee on PTSD warns that VA does not have sufficient capacity to provide outreach to new combat veterans and also meet the needs of veterans of past wars. In fact, VA PTSD services had been steadily losing capacity even before OEF/OIF began.

Table A-2 (page 169) of *The Long Journey Home Volume XI: Treatment of Posttraumatic Stress Disorder in the Department of Veterans Affairs* (Fontana, Rosenheck, Spencer & Gray, 2003) documents that the intensity of services in VA PTSD Clinics (measured by the number of visits per unique veteran) decreased by 13.2 percent since 1995. The number of veterans served by those programs doubled during that same period. Past Long Journey Home reports show that intensity of service in VA specialized PTSD outpatient programs has fallen against the 1995 benchmark at a progressively higher rate in each of the past three years (by 5.5 percent in 2000, 9.3 percent in 2001, and, as above, by 13.2 percent in 2002). Of particular note is Table E1 of Long Journey Home XI (p. 193), which shows where veterans actually receive outpatient PTSD care in VA. During FY 2002, a total of 202,862 veterans had a clinical visit in which PTSD was a focus of treatment *but only 29 percent of these veterans received treatment in a specialized PTSD program.* The remaining 71 percent received treatment in some other setting including 10 percent who received PTSD treatment in a *non-mental health setting.*

It is possible that there is a positive reading of this last bit of data. VA's Primary Care program is the de facto mental health system for the majority of those seeking VA care. Primary Care clinicians working side by side with Mental Health experts in recognition of that fact developed the new CPG. It incorporates specific modules that map the screening, diagnosis, and management of PTSD and other posttraumatic health issues in Primary Care settings and which define the crosswalk between Primary Care and Mental Health systems as appropriate to patient needs. To the extent that the finding that 10 percent of veterans receiving PTSD services may be receiving them in Primary Care, we may be seeing this system at work in a productive manner. But this is probably too optimistic a reading. VA must ensure that PTSD services are provided in Primary Care settings by design, not by default. We must then go on to ensure that these Primary Care services are fully integrated with general mental health and specialty PTSD services so that there is a true continuum of care available. This is an ideal rather than an actual practice in VA.

These findings underscore the pressing need to address PTSD and other post deployment mental health services across VA. While the Special Committee is pleased that VA will allocate additional resources for PTSD programs over the next three years, as authorized by P.L. 108-170, these funds will not be sufficient to meet the needs described in this report. Key among them is the development of programs that minimize the impact of new PTSD upon veterans and their families and which, if possible, prevent or minimize the effects of chronic PTSD.

If the human cost of PTSD and its related disorders is staggering, so are the long-term medical costs to VA associated with chronic PTSD. These stem from the symptoms of PTSD, itself, from mental health problems frequently associated with PTSD (including major depression and substance abuse), from the increased medical morbidity associated with chronic PTSD (Schnurr & Jankowski, 1999), from the significantly higher medical care utilization among veterans with chronic PTSD (Calhoun, Bosworth, Grambow, et al., 2002), and from the cost of disability compensation to veterans with chronic PTSD. While there is still only limited evidence that chronic PTSD can be prevented by early detection and intervention, clinical experience and sheer pragmatism demand that we try. In 1865, Abraham Lincoln invoked Congress and the nation "to care for him who shall have borne the battle and for his widow, and his orphan." VA must act now to engage a new generation of combat veterans and their families early and proactively in order to prevent or ameliorate chronic PTSD and its related post deployment disorders whenever possible. The potential cost offsets, human and financial, far outweigh the investment required.

Ongoing Recommendations of the Special Committee

As noted above, the Special Committee, in its First (2001) Annual Report, laid out 37 specific recommendations designed to meet the needs of veterans of past deployments. Faced with a rapidly evolving war in Afghanistan and Iraq and a pressing need for action, our 2003 report focused on three core priorities:

1. *Provide the range and intensity of specialized programs necessary to meet the service-related needs of veterans with PTSD*
2. *Promote best practices and evidence-based care for PTSD and other debilitating psychological responses to military trauma*
3. *Ensure VA's readiness to respond to the mental health consequences of combat, terrorism, and incidents of mass violence by supporting programs that are essential to its PTSD mission*

These priorities, the arguments supporting them, and actions recommended to address them are detailed in our Third Annual report. In order to maintain a sharp focus and a clear agenda for action, the Committee has closed out those of our original 37 recommendations that have been met and has, whenever possible, realigned the remaining recommendations with these three core priorities and their linked actions (see Attachment A). The remarks that follow

update each of the core priorities in terms of VA's response to date and the impact of subsequent events.

Priority 1: Provide the range and intensity of specialized programs required to meet the service-related needs of veterans with PTSD

Recommended Actions:

A. Establish a PTSD Clinical Team (PCT) at every VA Medical Center (VAMC)

As noted above, the original Special Committee on PTSD (established in 1984) called for a PCT at every VAMC but implementation has fallen far short of the goal. At present, there are 158 medical centers but only 86 PCTs. In our 2003 report, the Committee called for the establishment of a PCT at every VAMC. In his response to this issue, the Under Secretary for Health recognized that the numbers of veterans Service Connected for PTSD and receiving care for PTSD in VA are both increasing. He also noted that unmet need for PTSD services is indicated by the requests for PCTs and similar PTSD programs that could not be funded when the Millennium Veterans Health Care and Benefits Act was enacted. He agreed with the Committee that access to PTSD expertise should be available at all VA health care facilities, and stated that expansion of PCTs to VAMCs that do not yet have these programs, as well as other approaches will be considered. None-the-less, despite demonstrated need among current veterans and the certainty that many thousands of new combat veterans of Afghanistan and Iraq will soon be eligible for VA PTSD services, not a single new PCT has been added in the past year.

Medical center-based, PCTs are the hub for local PTSD services for veterans and their families. PCTs offer direct care but serve a much broader constituency by providing education, consultation and coordination of post deployment mental health care conducted throughout VA programs including inpatient and residential PTSD units, primary care clinics, CBOCs, and Vet Centers. PCT staff members serve as the primary educators of other VA staff about PTSD, as coordinators for ex-Prisoners of War (ex-POW) programs, and as prime movers in VA responses to workplace violence and local and national disasters. PCTs, where present, offer a critical link in the process by which the Seamless Transition Taskforce's VHA/DoD Liaisons, Points of Contact and Case Managers provide continuity of care for new combat veterans entering VA.

The Under Secretary's Special Committee on PTSD continues to press for the establishment of a PCT at every VAMC as a top priority in VA. VAMCs without PCTs should establish new PCTs. Those PCTs that are staffed below the minimum level defined in this Committee's 2003 Annual Report should be improved such that they meet or exceed that level. Mental Health Strategic Healthcare Group (MHSHG) is currently working with DoD to project which VAMCs across the country will be most heavily impacted by returning service

men and women and, in particular, by returning local Guard and Reserve units (Guard and Reserve are singled out because these units generally lack the mental health infrastructure available to active duty military men and women living on or near military bases). This data may be helpful in prioritizing the placement of future PCTs.

In its last report the Committee also recommended folding Military Sexual Trauma (MST) programs into the PCTs. The Under Secretary agreed that improved coordination of treatment of MST through the PCTs should be a target for program development. Progress in this area has been made in ongoing discussion between this Committee, MHSHG, and the Women Veterans' Health Care Group MST leadership team. This work will continue in the coming year.

B. Locate a family therapist within each Vet Center

One of the recommendations in our First Report (2001) was that VA expand the focus of PTSD treatment to include family assessment and interventions in order to help protect veterans and their families from the shattering effects of PTSD and other post deployment mental health problems (see Attachment A, Recommendation 23). PTSD continues to take a terrible toll on families resulting in estrangement, family violence, high rates of divorce, and homelessness. The recent cluster of murder-suicides in four Ft. Bragg families in the wake of deployment to Afghanistan focused attention on the seriousness of family readjustment issues. Expert opinion holds that marital and family relationships play an important role in the veteran's recovery from traumatic events (Riggs, 2000). Clinical experience strongly promotes family outreach as a core element of early intervention/prevention in work with new combat veterans. Veterans do not live in a vacuum. It is impossible to separate the readjustment issues of an individual veteran from those of his/her family.

Vet Centers have special expertise in working with families of combat veterans. This was recognized last year when Vet Centers were authorized to provide bereavement services to the families of combat casualties. With 206 community-oriented offices distributed across the US, Puerto Rico, the Virgin Islands, and Guam, RCS Vet Centers are natural access points for family PTSD services. In FY 2001, Vet Centers saw more than 128,000 veterans and had more than 900,000 visits from veterans and family members.

The Special Committee continues to recommend that a family therapist position be staffed at every Vet Center. In order to ensure that access to PTSD services is actually increased (and not simply redistributed through the assignment of collateral duties) the family therapist slot should be an additional staff position within each Vet Center.

The Under Secretary concurred with this recommendation in principle and recognized the value of providing family treatment to new combat veterans at Vet

Centers as authorized by 38 USC, section 1712A. He added that this recommendation is consistent with that made by the VA Advisory Committee on the Readjustment of Veterans in its 6th annual report to Congress dated July 10, 2002. Like the Special Committee, the Advisory Committee recommended that VHA augment the Vet Center's capacity to provide family counseling to traumatized veterans and family members by providing additional resources for qualified family therapists at Vet Centers, the number and location of which to be determined by the Under Secretary for Health in consultation with the Readjustment Counseling Service.

The Special Committee again presses for location of a dedicated family therapist in *every* Vet Center. This will be a vital link in the DoD/VA continuity of care as developed by the Seamless Transition Taskforce because VHA/DoD Liaisons at MTFs and POCs at VAMCs will be able to refer veterans' families to Vet Centers across the country. Services to families will include (but not be limited to) providing information about PTSD and other post deployment mental health issues, helping families identify and work with other VA programs, and directly implementing family interventions aimed at supporting family units and maintaining veterans within a strong, stable home.

Military families are a special population and therapists outside of DoD and VA do not always understand their unique issues. This is especially true in families of Guard and Reserve troops because they tend to be more isolated than family members of servicemen and women living on or around a military base. These augmented Vet Center-based family services could also prove of vital importance in support of families left behind during future military deployments, acts of terrorism, or other incidents of mass violence. While these would not be normal duties of family therapists at Vet Centers, it is a role that they could play at times of local, regional, or national emergency.

Priority 2: Promote best practices and evidence-based care for PTSD and other debilitating psychological responses to military trauma

One of VA's greatest resources is the expertise of its staff. VA cannot contract for PTSD services in the private sector because those resources don't exist outside of VA. This invaluable resource is renewable *if* staff education is comprehensive, continuous, and consistent with evidence-based best practices. Virtually all VA staff members have contact with veterans with PTSD. Training should address specific competencies needed by different staff members. In light of the events of September 11, 2001 and the ongoing threat of new acts of terrorism, the Committee has urged that training include information on emergency preparedness and acute intervention following combat and/or disaster. These considerations have led to the following recommendations for action:

A. Convene a National Education Steering Committee: The Joint DoD/VA Council on Post Deployment Mental Health

Note that this is a revision of our 2003 call for a National Steering Committee on PTSD Education necessitated by the clear importance of partnering across the entire DoD/VA continuum. In our First Annual Report (2001) we framed Recommendation 24: "VA should create a national PTSD education plan for VA staff with consistent access across the system." VHA agreed with this plan and identified the Mental Health Strategic Health Care Group (MHSHG), the National Center for PTSD (NC-PTSD), and the Employee Education System (EES) as partners in the process. Our Second Report urged that a Steering Committee on National PTSD Education be convened to develop a VA-wide education program, guide its implementation, and monitor its outcomes. In our Third Report, the Special Committee described this project as "the single most important step that VA could take to promote best practices and evidence-based care for PTSD and other debilitating psychological responses to military trauma." To date, this objective has not been met.

In his response to last year's report, the Under Secretary stated "In fact the National Center for PTSD (NC-PTSD) Educational Advisory Board performs this function already. Membership includes representation from Mental Health Strategic Health Care Group, Readjustment Counseling Service, Employee Education Service, and a Veterans Service Organization (The American Legion)."

The Special Committee must respectfully disagree with the Under Secretary on this point. We acknowledge that the National Center for PTSD performs invaluable educational services. Unfortunately its Advisory Board, while expert, has neither the charge nor the scope of membership necessary to develop the national plan that the Special Committee is calling for. As noted in our past reports, this would require inclusion of all the elements of the NC-PTSD's Educational Advisory Board *plus* the Military Sexual Trauma Program, those Mental Illness Research, Education, and Clinical Centers (MIRECCs) that have placed a special emphasis on PTSD, and VBA (with special emphasis on evaluation of new combat veterans). Based on experience over the past year and the importance of developing an effective transition across the DoD/VA continuum, the committee should also include representatives of DoD and of VA's Seamless Transition Taskforce. In short, the group that must be assembled is significantly more diverse than the NC-PTSD Educational Advisory Board and its goals, while complementary with those of the NC-PTSD, are much broader.

The mission of the Joint DoD/VA Council on Post Deployment Mental Health will be to review the present continuum of care, design an educational plan based on a national needs assessment undertaken across DoD and VA, develop an implementation strategy based on evidence-based teaching methods, create an appropriate set of outcome monitors, and provide an estimate of funding

necessary to achieve these goals. In view of current educational needs across DoD and VA, this recommendation is even more imperative now than it was a year ago.

In order to "jump start" the work of the Joint DoD/VA Council on Post Deployment Mental Health, we recommend that it be built upon the membership of the Work Group that recently developed the Joint VA/DoD Clinical Practice Guideline for the Management of Traumatic Stress. This group represents most of the constituencies required and has already developed a common language, strong rapport and mutual respect over the course of over two years of productive inter-departmental efforts in the service of post deployment mental health.

Another advantage of basing the new Council on the Clinical Practice Guideline Work Group is that its efforts will center on the rollout and implementation of the CPG. The CPG is a powerful new tool that incorporates specific modules that map the screening, diagnosis, and management of PTSD and other post-traumatic disorders in operational and clinical settings. It creates a common language for DoD and VA, defines a crosswalk between primary care and mental health systems as appropriate to patient needs and has the potential to create a clinical record/data base that follows veterans individually and in groups across the DoD/VA continuum of care. This evidenced-based informational template is capable of transforming the DoD/VA continuity of care but only if it is implemented across both systems and supported by a coordinated educational effort and by the development of software which facilitates its application in clinical settings.

B. Identify a PTSD Coordinator within each VISN and RCS Region and, in coordination with VA Central Office, convene them as a National PTSD Continuity Committee

One of the Under Secretary's Special Committee's prime tasks is to ensure that VA's national PTSD program does not founder in the wake of VA's division into 22 semi-autonomous Veterans Integrated Service Networks (VISNs) in FY 1996 (currently 21 VISNs). To address this concern, the Special Committee recommended in its First Annual Report "PTSD coordinators be identified within each VISN in order to ensure that the PTSD continuum of care is appropriately structured and implemented within each VISN" (p. 48). The VISN Director (in consultation with the Coordinator, Mental Health Service Line, where such exist) would appoint the VISN PTSD Coordinator. In its response to the Committee's second report, VHA concurred with the value of having coordinators for PTSD care within each Network. VHA went further in stating that "a Continuity Committee will be established including VA Central Office (VACO), and Network participation and a list of Network and RCS PTSD coordinators will be created and shared with the Committee and across the system" (Second Annual Report, p. 25). To date, no action has been taken to implement this plan.

The current national situation calls for immediate identification of a PTSD Coordinator in each VISN. The Coordinator would be tasked with ensuring that each VAMC and CBOC has a plan for meeting the needs of veterans with PTSD including new combat veterans of OEF and OIF. Appropriate FTEE and resources should be set aside for this work. The Coordinator would be responsible for championing local implementation of the CPG. Each Coordinator would work with their respective VISN leaders to identify the needs of local veterans and to allocate sufficient resources to meet those needs. The PTSD Coordinator would champion the implementation of the Seamless Transition Plan within each VISN and across the DoD/VA continuum of care.

The VISN PTSD Coordinator would be responsible for working with the VISN Director to assure that PTSD/post deployment performance measures are met. VA requires that capacity be maintained in terms of numbers of veterans with PTSD treated and also requires screening for history of MST. The Office of Quality and Performance is currently developing a new PTSD performance measure based on the 4-item PTSD screening tool used in the CPG. By monitoring the use of this evidence-based screening tool, this new measure will raise awareness of the new CPG and encourage its implementation.

In short, the VISN PTSD Coordinator would be responsible for ensuring that each Network either contain or have working access to the full continuum of specialized PTSD services and post deployment mental health services. Coordinators would serve as hubs connecting facility and Network programs with national programs to ensure communication and optimal integration of these services throughout VA and in partnership with DoD. VISN PTSD Coordinators could be particularly effective in coordinating outreach and engagement efforts with local Guard and Reserve Units and with DoD staff at local military bases (as per the plans described above). They would also be able to provide vital coordination of VA efforts in response to local, regional, and national disasters. The establishment of a National PTSD Continuity Committee would be of decisive value in establishing the continuity of VA's national post deployment mental health program.

Priority 3: Ensure VA's readiness to respond to the mental health consequences of combat, terrorism, and incidents of mass violence by supporting programs that are essential to its PTSD mission

VA's response to the mental health consequences of combat and national emergencies depends on consistent support for its national infrastructure and on the vision and scope of its research. Our recommendations for action are:

A. Support VA's National Center for PTSD

The National Center for PTSD supports VA's clinical expertise, national infrastructure, and graduated levels of PTSD care through its comprehensive

research, educational, and consultative activities. The National Center maintains the world's most comprehensive and widely used PTSD website (www.ncptsd.org). The National Center website is home to the Iraq War Clinician Guide (now in its second revision). The Iraq War Clinician Guide is a concise and authoritative aid to practitioners and policy makers across the country and around the world. It is the single best guide to clinical work with returning combat veterans and their families. It builds upon the National Center's long tradition of leadership and excellence. As noted above, the Iraq War Clinician Guide could easily provide the core syllabus for education on post deployment mental health across VA and DoD.

The National Center has a proven track record of interdepartmental and international collaboration. They have developed the world's largest and most sophisticated PTSD bibliographical resource, the Published International Literature on Traumatic Stress (PILOTS) Database which can be freely accessed by clinicians, researchers, and policy makers through the website.

Since September 11, 2001, the National Center for PTSD has been called upon to develop and direct urgently needed responses to the mental health consequences of terrorism. Demand on the National Center greatly accelerated with the onset of Operation Enduring Freedom and Operation Iraqi Freedom. Sustained activity at this level requires a stable, multiyear baseline budget but the National Center's budget is still determined on a year-to-year basis. This severely handicaps its ability to engage in multiyear planning and to undertake multiyear projects in post deployment education and research that will be urgently needed over the coming years. The Committee recommends that the National Center for PTSD be funded at a stable multiyear baseline and at an increased level.

B. Support the National Vietnam Veterans Longitudinal Study

The National Vietnam Veterans Readjustment Study (NVVRS), completed in 1988, is the source authority on the nature and course of combat-related PTSD. Commissioned by Congress, this was the first national mental health epidemiological study in US history. Preparation is now underway for the National Vietnam Veterans Longitudinal Study (NVVLS), which will provide follow up data on the same group of veterans included in NVVRS. NVVLS will broaden the design of the original study to yield new information on the psychiatric, social, and, in particular, the physical health outcomes of these combat veterans. NVVLS will provide vital new information for VA clinical operations and for VA mental health planning with respect to PTSD and its co-morbid disorders. The results of this study will be fundamental to VA's understanding of the needs of veterans now and in the future. Although this study is being conducted on Vietnam veterans, its findings will play a crucial role in defining VA plans and policies for the continuing treatment of OEF and OIF veterans. Like the NVVRS

before it, NVVLS will define post-deployment practice and research for years to come. It is VA's next step in moving science into practice.

At present, funding for the NVVLS is being drawn from medical care dollars allotted to the National Center for PTSD. This is withdrawing critical resources from the National Center at precisely the same time that it is trying to take on important new tasks on behalf of returning combat veterans. The original NVVRS was funded directly by Congress such that VA was not "taxed" in order to complete it. The Special Committee recommends that a line item be established for NVVLS funds so that its funding is clearly established and so that it does not encumber other vital VA efforts to meet the post deployment needs of veterans already under our care or of new combat veterans and their families.

C. Identify PTSD as a VA Research Priority

This is a revision of the call in our Third Annual Report to identify PTSD as a VA Designated Research Area. Ongoing changes in VA's Research program will likely make the idea of developing a Designated Research Area for PTSD moot. The Special Committee stands by to work with top VA Research leaders to define a research agenda for post deployment mental health.

With every crisis comes opportunity. The return of new combat veterans, the recent release of the Clinical Practice Guideline on the Management of Traumatic Stress, the development of a performance measure that will press for screening every veteran in VA for PTSD and new levels of collaboration across the DoD/VA Continuum all combine to create important research opportunities. VA has the potential to establish the world's largest database on the prevalence of PTSD and to study the effects of early intervention on its long-term course and complications. Knowledge gained would be of immense value to VA and to the nation. It would provide the basis of new evidence-based interventions to be implemented during future deployments and/or after terrorist attacks. This new knowledge would guide clinical and research efforts in VA for years to come. Potential partners in this work include the National Center for PTSD, those MIRECCs that include PTSD as a focus, VA's Health Services Research and Development Centers, its Geriatric Research, Educational and Clinical Centers, the Uniformed Services University of the Health Sciences, other DoD components, and the National Institutes of Mental Health.

Conclusion

The actions recommended in this report will enable VA to meet the present challenge and prepare us for future challenges. It is time to act on behalf of those who have borne our nation's latest battles and to prepare for future operations. The prospective stance and new focus on the larger spectrum of post deployment mental health diagnoses and functional problems advocated here will transform VA's PTSD programs and vastly increase their relevance and

efficacy. In times of peace, VA can keep its post deployment skills sharp by responding to veterans of past deployments, MST, workplace violence, and local, regional, and national disasters. Although it has taken a new war to force a paradigm shift, it is clear that this action has long been needed across the DoD/VA continuum.

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Under Secretary for Health's Response to the Recommendations of the Special Committee on PTSD

The Under Secretary for Health's Special Committee on PTSD's 2004 Report provides text supporting seven key recommendations as well as a spreadsheet (Attachment A) tracking past recommendations. This response focuses on the seven key recommendations.

■ ■ ■

1. Provide the range and intensity of specialized programs necessary to meet the service-related needs of veterans with PTSD

Recommended Actions:

A. Establish a PTSD Clinical Team (PCT) at every VA Medical Center

Response: Concur in concept. The numbers of veterans rated with a service connection for PTSD and receiving care for PTSD in VA are increasing. As noted in last year's report, field facilities would expand specialized PTSD services were additional funds available. This statement is based on the number of requests received to enhance PTSD services with funds provided by the Millennium Veterans Health Care and Benefits Act. The return of new combat veterans from Afghanistan and Iraq will lead to additional demand for PTSD services.

VHA remains committed to providing PTSD treatment to all veterans needing this service. Where workload and resources permit, VHA will consider the establishment of PCTs and other specialized PTSD services, as well as other treatment approaches, at VAMCs and clinics that do not have these programs or require program enhancement. Section 108 of P.L. 108-170 authorized, among its many provisions, $5 million to enhance PTSD services. These monies will be made available for three fiscal years and will increase the availability of needed PTSD services. Although all VISNs will have an opportunity to request support, priority funding will be given to those networks with lower market penetration based upon population based measures and/or with needs in high priority areas including PCTs, womens programs, returning OIF/OEF veterans, etc. In addition, the Mental Health Strategic Planning initiative is scheduled to deliver its final product to the Secretary in July 2004. This comprehensive strategic plan will cover the entire continuum of mental health care, including PTSD. This will provide a comprehensive blueprint for the delivery of mental health care and enhance planning for PTSD services and their integration within the entire mental health continuum.

B. Locate a family therapist within each Vet Center

Response: VHA concurs in principle with this recommendation, recognizing the value to war-traumatized veterans of providing family treatment at Vet Centers as authorized by 38 USC, section 1712A. This recommendation is also consistent with the recommendation of the Advisory Committee on the Readjustment of Veterans as made in the Committee's 6th annual report to Congress dated in July 2002. The Advisory Committee recommended that VHA augment the Vet Center's capacity to provide family counseling to traumatized veterans and family members by providing additional resources for qualified family therapists at some Vet Centers, the number and location of which to be determined by the Under Secretary for Health in consultation with the Readjustment Counseling Service (RCS).

The provision of holistic services to veterans and family members is a core component of VA's community-based Vet Center program. The Vet Centers combine professional readjustment counseling for war trauma with family work, outreach and community coordination of care. To date the Vet Centers have provided transition services to over 6,800 Global War on Terrorism (GWOT) veterans, approximately one third of whom are receiving ongoing services for various social and psychological post-war readjustment problems. Since the onset of Operation Iraqi Freedom in March 2003, the Vet Centers have also been actively pursuing the program's community-based service mission by way of conducting systematic outreach to military installations targeted to receive returning troops from Afghanistan and Iraq, with particular attention to National Guard and Reserve personnel returning to their home communities following their deployment. Vet Center staff visits to military installations, and to National Guard and Reserve components, promote coordination with DoD Family Assistance Centers to provide a continuum of care for separating service men and women. Within the context of the Vet Center program's outreach activities, family members of service men and women deployed to the Global War on Terrorism are provided with educational information, case management and referral services by Vet Center staff. Following Secretarial authorization granted in August 2003, the Vet Centers are now providing bereavement counseling to surviving family members of Armed Forces personnel who died while on active duty in Afghanistan and Iraq. Referrals to the Vet Centers for this program are primarily coordinated through military casualty assistance officers and the casualty assistance component of VBA.

2. Promote best practices and evidence-based care for PTSD and other debilitating psychological responses to military trauma

Recommended Actions:

A. Convene a National Steering Committee: The Joint DoD/VA Council on Post Deployment Mental Health

Response: Concur in concept. This is a revision of the Committee's 2003 recommendation for a National Steering Committee on PTSD Education. The Committee believed such a revision was necessitated by the increasing importance of partnering across the entire DoD/VA continuum. To date, the National Center for PTSD (NCPTSD) Educational Advisory Board has been a successful enterprise with a number of key educational projects coming to fruition including the ethno-cultural video series, CAPS assessment CD Rom and Compensation and Pension Examination manual and training. In addition, this planning group has collaborated with Mental Illness Research Education and Clinical Centers (MIRECCs) and Readjustment Counseling Service (RCS) on trainings over the past several years.

The present recommendation proposes a Steering Committee with a broader scope and purpose than the Educational Advisory Board with participation from a wider range of stakeholders. To accomplish this broader mission, the NCPTSD is directed to convene a National Education Steering Committee as proposed. Steering Committee membership should be developed with guidance from and input/collaboration with the Special Committee on PTSD. The Steering Committee will be charged to design an educational plan based on a national needs assessment across the VA/DoD continuum, develop implementation strategies, create an appropriate set of outcome monitors and identify appropriate sources of support.

The proposal to form a Joint DoD/VA Council on Post Deployment Mental Health, which is mentioned here in an educational context, is also mentioned prominently in a number of domains in Appendix. A. In the Appendix, potential roles for this council extend well beyond the educational focus of this recommendation and assign an overarching coordination and oversight function for all post deployment issues related to mental health. The MHSHG will be asked to establish the proposed Council with input from RCS and other stakeholders. The VA/DoD Joint Council on Post Deployment Mental Health would coordinate activities in relation to mental health issues and their integration with other health care of returning veterans. The council would serve as a subcommittee reporting to an existing VA/ DoD group such as the Post Deployment Work Group.

B. Identify a PTSD Coordinator within each VISN and RCS Region and, in coordination with VA Central Office, convene them as a National PTSD Continuity Committee

Response: Concur in part. Readjustment Counseling Service has established Vet Center Coordinators in each VISN to ensure an appropriate level of coordination between medical facilities and local Vet Centers. The Mental Health Strategic Healthcare Group in collaboration with the VISN Mental Health Liaisons will establish designated PTSD Coordinators for each VISN. Vet Center Coordinators and VISN PTSD coordinators will assume responsibility for

ensuring an effective continuum of PTSD care for veterans. VISN Mental Health Liaisons may assume the duties of the PTSD Coordinator or identify another suitable individual from within the VISN. The proposed VA/DoD Council on Post Deployment Mental Health will address the need for a National PTSD continuity committee.

3. Ensure VA's readiness to respond to the mental health consequences of combat, terrorism, and incidents of mass violence by supporting programs that are essential to its PTSD mission.

Recommended Actions:

A. Support VA's National Center for PTSD

Response: Concur as follows. The Under Secretary for Health (USH) concurs in principle with this recommendation. It is clear that the National Center for PTSD is an outstanding resource for VA and for the nation not only in promoting research and education on PTSD, but also in providing tangible support for staff and patients alike through products such as the NCPTSD web site disaster response page, and the Iraq War Guide. Core funding for the NCPTSD is essentially stabilized over the years through Special Purpose Funding with standard inflationary increments. Requests for funding increases as assessed for specific needs or projects (e.g. VA Cooperative Study #494 on exposure therapy for female veterans). The National Center has excelled in successfully competing for grants, holding 82 grants, which brought research funding to over $17 million for FY 2003. It is anticipated that this funding pattern: stable core funding supplemented by grants from within or external to VA, will continue.

B. Support the National Vietnam Veterans Longitudinal Study

Response: The manner under which the National Vietnam Veterans Longitudinal Study (NVVLS) will be completed is currently under review. The NVVLS project has been supported by funds from the Special Purpose account. It is understood that during the period when NVVLS has not had such funding, several support staff for the project have been carried by NCPTSD funds. When the NVVLS project resumes, support for the project will be again covered by NVVLS funds.

C. Identify PTSD as a VA Research Priority

Response: Concur in concept. The USH concurs that collaborative research between VA and non-VA partners dedicated to the service of troops engaged in the Global War on Terrorism is a worthy goal and one that should be

attainable. The Mental Health Strategic Health Care Group is charged with developing a work group of Mental Health, Extended Care and Research Service staff to develop and implement these plans through the proposed VA/DoD Post Deployment Mental Health Council.

Estimate of Cost to Prepare Congressionally-Mandated Report

ATTACHMENT

Short Title of Report: 4th Annual Report - Committee on PTSD

Report Required By: The Veterans Millennium Health Care and Benefits Act of 1999

In accordance with Title 38, Chapter 1, Section 116, the statement of cost for preparing this report and a brief explanation of the methodology used in preparing the cost statement are shown below.

Manpower Cost:	$39,480
Contract(s) Cost:	$0
Other Cost:	$0
Total Estimated Cost to Prepare Report:	$39,480

Brief Explanation of the methodology used in preparing this cost statement:
The hourly rates of pay (plus 25.56 for benefits) of the employees involved in preparing the report were multiplied by the number of hours each employee spent on the report. The figures were then totaled to arrive at the estimated cost.

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CLINICAL SECTION		Status Due Date		
DOMAIN 1 - Sustaining specialized PTSD Services in VA (Encompasses the following recommendations from the Committee's first report) **RECOMMENDATION (S) 1- 4**	**OBJECTIVE**	**M**	**N M**	**P**
Recommendation 1: Specialized PTSD programs should be recognized as a critically important component of VA expertise and service. In addition to meeting a core need of VA (provision of mental health services for veterans suffering from the single most prevalent mental disorder arising from combat), these programs maintain America's readiness to deal with survivors of future wars, disasters and acts of terrorism and mass destruction. The lack of specialty services during and after the Vietnam War resulted in misunderstandings and delays that contributed to the immense medical and social consequences associated with PTSD. These include (but are not limited to) chronic PTSD, substance abuse, depression, increased utilization of medical services, unemployment, disability, broken families, poverty, homelessness, and alienation. **Recommendation 2:** Top management needs to develop, announce, and apply clear and prompt consequences when Veterans Integrated Service Network (VISN) leaders close PTSD programs without authorization. Such procedures should be developed by the Mental Health Strategic Health Care Group (MHSHG) in consultation with the National Center for PTSD (NC-PTSD) and with this Committee. **Recommendation 3:** System-wide administrative mechanisms should be established to ensure that, when PTSD programs are closed, the resources freed up by the closure are reinvested in other types of PTSD programs. This will ensure that VA does not lose its capacity to treat PTSD. **Recommendation 4:** The Committee will work with top VA leadership to develop a VISN Director's Performance Measure aimed at maintaining capacity to treat PTSD within each VISN and at ensuring that PTSD resources, when reassigned, remain within the PTSD continuum of care.	VA should establish a VISN Director's Performance measure aimed at maintaining the capacity of specialized PTSD programs such that if or when such programs are closed, the resources remain within the PTSD Continuum of care. **(Priority I)**	X		
COMMENTS: The Committee determined this objective to be met based on the Congressional mandate that capacity be maintained in VA PTSD programs. It is, however, unclear whether maintaining baseline capacity as defined in terms of the number of veterans treated and dollars spent (unadjusted for inflation) compared to the baseline year adequately prepares VA to meet future challenges such as those of treating new combat veterans of OEF/OIF or managing the PTSD workload that may be associated with Military Sexual Trauma (still an unknown quantity in VA). The Committee will follow the issues raised in this Domain by tracking progress on our recommendations to establish a PTSD Clinical Team (PCT) at every VA medical center, to locate a family therapist within each Vet Center, and to identify a PTSD Coordinator within each Veteran Integrated Service Network (VISN) and Readjustment Counseling Service (RCS) region. Item closed.				

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CLINICAL SECTION		Status Due Date		
DOMAIN 2 – Assessment of PTSD **RECOMMENDATION (S) 5-6**	**OBJECTIVE**	**M**	**N M**	**P**
Recommendation 5: VA should develop and implement a nationally standardized assessment battery for PTSD [VA's Northeast Program Evaluation Center (NEPEC) and the National Center for PTSD are in the process of piloting such a system]. **Recommendation 6:** Every Community-Based Outpatient Clinic (CBOC) should have a PTSD screening mechanism in place and should define how veterans who screen positive for PTSD will gain access to PTSD services.	1. Develop a brief screening tool that will reliably identify new cases of PTSD in general treatment settings. 2. Develop a separate assessment tool/battery that reliably diagnoses PTSD and monitors progress in treatment of individual patients. (Priority 2)	X X		
COMMENTS: Objective 1 has been met by development of the National Center for PTSD's Primary Care PTSD Screening Tool (PC-PTSD) that is now incorporated in the Joint VA/DoD Clinical Practice Guideline for the Management of Traumatic Stress and in DoD's Post Deployment Health Screen. The Committee strongly recommends that the PC-PTSD be the focus of a new Director's Performance Measure on PTSD Screening in Primary Care and Mental Health settings across VA. The Performance Measures Work Group is currently considering such a measure. Objective 2 has been met by the development of the National Center's PTSD Checklist (PCL). The National Center is currently piloting a new program evaluation measure that will assess functional outcomes as a means of gauging response to PTSD treatment in VA. Item Closed.				

CLINICAL SECTION		Status Due Date		
DOMAIN 3 – Optimizing the continuum of care for PTSD in VA **RECOMMENDATION (S) 7-12**	OBJECTIVE	**M**	**N M**	**P**
Recommendation 7: The clinical database derived from the standardized assessment battery (as per Recommendation 5) and the medical record of the veteran with PTSD, must follow the veteran across the VA system. The Committee should work with VA medical record specialists and computer experts to develop a system for sharing pertinent clinical data across the entire PTSD continuum of care. This is "One VA." **Recommendation 8:** PTSD coordinators should be identified within each VISN in order to ensure that the PTSD continuum of care is appropriately structured and implemented within each VISN.				

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CLINICAL SECTION		Status Due Date		
DOMAIN 3 – Optimizing the continuum of care for PTSD in VA **RECOMMENDATION (S) 7-12 (continued)**	**OBJECTIVE**	**M**	**N M**	**P**
Recommendation 9: The present continuum of care established to treat PTSD in VA needs improved coordination and further refinement. As per the Report to Congress on the Implementation of Public Law 106-117, the continuum of care should include: • Early identification and intervention; • Assessment, triage and referral; • Acute stabilization and intervention (including option for hospitalization in a general psychiatric unit or a specialty PTSD unit as clinically appropriate); • Treatment and rehabilitation, involving short or longer-term care on an outpatient or residential basis; • Other outpatient care, encompassing continuing care, monitoring, and relapse prevention for those with substance use disorder co-morbidity. **Recommendation 10:** Because PTSD is a chronic condition with frequent co-morbid psychiatric and medical conditions; sustained treatment settings of varying intensities are required. **Recommendation 11:** When a veteran is treated for PTSD at a VA medical center (VAMC), but has a follow-up at a Readjustment Counseling Service (RCS) Vet Center, that appointment should satisfy VA performance standards for follow-up care. **Recommendation 12:** VA Medical Centers and Readjustment Counseling Service need to work together to ensure full collaboration in the service of veterans with PTSD. The Committee recognizes the unique contributions of VAMCs and RCS and the critical importance of maintaining their distinct identities. At the same time, we advocate innovations including (but not limited to): • A common PTSD database for each veteran with PTSD. • Joint access to clinical notes relevant to PTSD treatment across the two systems. • A joint VAMC/RCS assessment of local and national needs within each system that could be addressed by sharing clinical resources through such programs as Co-location and Telemedicine.	1. A Continuity Implementation Planning Committee composed of representatives of Veterans Health Administration (VHA), RCS, VBA, Information Resource Management Service (IRMS), and the General Counsel's Office, should be established for the purpose of developing appropriate access to clinical data across VA's PTSD continuum of care. 2. The VISNs and RCS will provide a list of names of coordinators or members of their respective coordination groups for membership on this new committee. (Priority I)		X X	
COMMENTS: Objective 1 has not been met. The Committee notes that progress is being made in integrating medical records across the DoD/VA continuum of care. We also note that the development of the CPG opens the possibility that clinical notes based on the CPG could follow the patient from DoD into both VAMCs and RCS. These issues need to be addressed by the Continuity Implementation Planning Committee, which has yet to be formed. This issue can be turned over to the Joint VA/DoD Council on Post Deployment Mental Health called for in this report. Objective 2 has not been met and continues as a core action proposal in our FY04 annual report.				

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CLINICAL SECTION		Status Due Date		
DOMAIN 4 – "Best Practice" guidelines for PTSD treatment in VA RECOMMENDATION (S) 13-16	**OBJECTIVE**	**M**	**N M**	**P**
Recommendation 13: VA should disseminate and implement "best practice" PTSD treatment guidelines. **Recommendation 14:** Special guidelines should be developed for work with aging veterans; for ethnic and cultural groups shown to have different risks and needs with respect to PTSD; for veterans of peacekeeping missions; for female and male survivors of sexual and other non-combat trauma in the military; and for other populations for whom specific needs are identified. **Recommendation 15:** More effective treatment approaches are needed for veterans with PTSD and co-morbid substance abuse. These include improved methods of identifying PTSD among substance abusers. **Recommendation 16:** In addition to aiming at decreasing PTSD severity, treatment efforts should be directed toward decreasing the effects of co-morbid conditions, improving function, and improving social support systems. This "rehabilitation" perspective is more appropriate in dealing with a chronic and complex disorder.	A work group should be formed to develop these best practice guidelines. (Priority II)	X		
COMMENTS: This item is closed.				

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CLINICAL SECTION		Status Due Date		
DOMAIN 5 – "Integration of care for patients with PTSD" **RECOMMENDATION (S) 17-18**	**OBJECTIVE**	**M**	**N M**	**P**
Recommendation 17: The medical problems of our aging population of veterans with PTSD require an integrated approach of Primary Care, Geriatric, and PTSD experts. Cooperative efforts between Primary Care Clinics, Specialized PTSD Programs, and the Geriatric Research, Education, and Clinical Centers (GRECCs) should be explored, perhaps in partnership with VA's Health Services Research and Development Program (HSR&D). **Recommendation 18:** Better coordination of care is needed between specialized PTSD programs and VA Medicine and Surgery clinics, including those in community-based outpatient clinics (CBOCs). The goal is to improve health habits and identify and manage co-morbid medical disorders. This will improve health-related quality of life and lower unnecessary health care costs.	Implement a study to determine what access patients with PTSD have to Primary Care in VA. A patient's age should be one factor studied in relation to this access. (Priority II)	X		
COMMENTS: This item is closed.				

CLINICAL SECTION		Status Due Date		
DOMAIN - None cited **RECOMMENDATION (S) 19**	**OBJECTIVE**	**M**	**N M**	**P**
Recommendation 19: Increased access to care is needed. This can be facilitated through the continued expansion of Vet Centers, RCS outstations, CBOCs (with specialized PTSD services), and Telemedicine services into under-served geographic areas.	The Committee requests a list of expansion sites currently under consideration. (Priority II)		X	
COMMENTS: This objective has not been met. The Committee will follow this issue by tracking progress on our recommendations to establish a PTSD Clinical Team (PCT) at every VA medical center, to locate a family therapist within each Vet Center, and to identify a PTSD Coordinator within each Veteran Integrated Service Network (VISN) and Readjustment Counseling Service (RCS) region. The Committee recognizes recent growth in CBOCs across the nation but also notes that access to PTSD services are, as yet, limited at those sites. Considerable progress has been made in Telemedicine in Mental Health and the Committee will follow this process in order to gauge improvements in access to PTSD services.				

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CLINICAL SECTION		Status Due Date		
DOMAIN - None cited **RECOMMENDATION (S) 20**	**OBJECTIVE**	**M**	**NM**	**P**
Recommendation 20: Veterans who have suffered sexual trauma while on active military duty have been granted access to counseling and treatment for their post-traumatic medical needs regardless of their income status (38 USC 1720D). The same level of access should be applied to all veterans seeking counseling and treatment stemming from psychological trauma during active military duty.	Propose legislative language that will grant cost-free PTSD treatment for all veterans with PTSD-related to military service. (Priority II)		X	
COMMENTS: VHA responded that it would be unfair to provide cost-free services to Category C veterans who suffer from PTSD and believes that it would be more appropriate for such veterans to seek service connection for relevant conditions. The Committee again points out that providing access to services to veterans with PTSD as a direct consequence of their military service is a core function of VA. We believe that this principle is reflected in VA's recent decision to provide VA services to Guard and Reserve members for the first two years after OEF/OIF deployment. This level of access is also being provided for veterans with a history of military sexual trauma. The same level of access should be provided for all veterans who have served in a war zone and screen positive for post deployment traumatic stress. This is consistent with the recommendations laid out in this report relating to seamless transition between DoD and VA.				

CLINICAL SECTION		Status Due Date		
DOMAIN - None cited **RECOMMENDATION (S) –21**	**OBJECTIVE**	**M**	**NM**	**P**
Recommendation 21: VA should extend its effort to monitor the productivity and quality of specialized PTSD services across the PTSD continuum of care, including measures of functionality, quality of life and social support.	The Committee requests a progress report on the monitoring plan as identified above. This report should specify a timetable and the resources required for full implementation. (Priority II)		X	
COMMENTS: As noted above, the National Center for PTSD is in the process of piloting a measure of functionality as a further test of the quality of PTSD services in VA. It is expected that this measure will include a valid scale for quality of life and social support. The Committee has worked with the National Center on this measure and will follow its progress.				

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CLINICAL SECTION		Status Due Date		
DOMAIN - None cited **RECOMMENDATION (S) -22**	**OBJECTIVE**	**M**	**N M**	**P**
Recommendation 22: VA PTSD services need to be coordinated and, where possible, integrated with those of DoD, Federal Emergency Management Agency (FEMA), and other Federal and non-Federal agencies. This would facilitate VA's mission of backing up DoD and community resources during times of emergency under the National Disaster Management Act. It would also produce a much-needed synergy of clinical efforts through an increased emphasis on primary and secondary prevention of PTSD.	A Committee on Emergency Mental Health Preparedness should be established to review the current readiness of VA to respond to crisis situations and to develop a plan for regional and national response in coordination with appropriate agencies. (Priority I)	X		
COMMENTS: This item is closed. Related issues will be followed by the Joint DoD/VA Council on Post Deployment Mental Health called for in this report.				

CLINICAL SECTION		Status Due Date		
DOMAIN - None cited **RECOMMENDATION (S) -23**	**OBJECTIVE**	**M**	**N M**	**P**
Recommendation 23: VA must expand the focus of PTSD treatment, to include family assessment and intervention, in order to help protect veterans and their families from the shattering effects of PTSD. In doing so, VA is following the mission set by Abraham Lincoln who understood that veterans services are never just about the veteran, but his/her spouse must be considered as well.	The Committee requests a report outlining VA plans to provide services to the families of veterans suffering from PTSD. (Priority I)		X	
COMMENTS: No report has been received. This issue will be followed by the Joint DoD/VA Council on Post Deployment Mental Health (which will assess and redefine the DoD/VA continuum of care for individuals and families) and will also be reflected by compliance with the Committee's call for the addition of a family therapist at every Vet Center as per this report. This is a basic access issue, the importance of which has been made clear by the stress on families during OEF/OIF deployments and by the importance of family support in the recovery of combat veterans with post deployment mental health problems.				

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EDUCATION SECTION		Status Due Date		
DOMAIN - None cited **RECOMMENDATION (S) 24**	**OBJECTIVE**	**M**	**NM**	**P**
Recommendation 24: VA should create a national PTSD education plan for VA staff with consistent access across the system. Committee membership should include, but not be limited to, representatives of MHSHG, RCS, EES, NCPTSD, NEPEC, this Special Committee, and field representatives from VISNs and Vet Centers.	A Steering Committee on National PTSD Education should be convened to develop an education plan, guide its implementation, and monitor its outcomes. As a part of this process, the Steering Committee should develop a range of competencies appropriate to the educational needs of different components of VA staff and assure that the necessary training will be provided to each component. Specific competencies could be linked with the High Performance Development Model. (Priority I)		X	
COMMENTS: Although a number of important educational initiatives have been undertaken by the National Center for PTSD and the Seamless Transition Task Force (note especially the Iraq War Clinician Guide which is posted on the National Center's website), no comprehensive national education plan has been developed. Ongoing issues related to this will be followed by the Joint DoD/VA Council on Post Deployment Mental Health called for in this report.				

EDUCATION SECTION		Status Due Date		
DOMAIN - None cited **RECOMMENDATION (S) 25**	**OBJECTIVE**	**M**	**NM**	**P**
Recommendation 25: **VA should develop multidisciplinary credentialing standards for VA clinicians specializing in PTSD.**	The Steering Committee on National PTSD Education described in Recommendation 24 (above) will prepare a White Paper specifically addressing the issue of multidisciplinary credentialing standards for VA clinicians working in specialized PTSD programs. **(Priority I)**		X	
COMMENTS: Ongoing issues related to this will be followed by the Joint DoD/VA Council on Post Deployment Mental Health called for in this report. The curriculum for such a credentialing process is already largely available in VA thanks to recent projects including the Iraq War Clinician Guide and PTSD 101 (both developed by the National Center for PTSD) as well as the recent Veterans Health Initiative on Caring for War Wounded.				

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EDUCATION SECTION		Status Due Date		
DOMAIN - None cited **RECOMMENDATION (S) 26**	**OBJECTIVE**	**M**	**NM**	**P**
Recommendation 26: **VA should improve Educational Collaboration with the Department of Defense.**	The Committee requests a summary of VA-DoD collaborations to date and of existing plans for improving educational collaboration on traumatic stress between the two agencies. **(Priority II)**		X	
COMMENTS: The Committee commends the VA/DoD work group that developed the recently released Joint VA/DoD Clinical Practice Guideline for the Management of Traumatic Stress and recommends that the Joint DoD/VA Council on Post Deployment Mental Health called for in this report be built upon that same work group in order to take advantage of the trust and working relationships already developed across the DoD/VA continuum of care.				

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RESEARCH SECTION		Status Due Date		
DOMAIN 6 – Funding for Research **RECOMMENDATION (S) 27-28**	**OBJECTIVE**	**M**	**NM**	**P**
Recommendation 27: Research Service should work with the Special Committee to compare and evaluate the process for funding PTSD projects in order to establish appropriate research goals and research funding targets. **Recommendation 28:** Consideration should be given to identifying PTSD as a Designated Research Area, with a subcommittee within VA Research and Development that specifically reviews PTSD-related research.	The Committee requests a summary of discussions between MHSHG and Research Service to date, as they pertain to Recommendations 27 and 28. Further, in order to allow the Committee to determine the sufficiency of funding for PTSD research, we also request that MHSHG obtain from Research Service the following information for the last five fiscal years 1. The number of VA-funded research projects in which PTSD is a primary focus. 2. The total amount of funding for these projects on an annual basis. 3. The number of VA-funded research projects and amount of funding for all other mental health research projects where PTSD is not a primary focus. 4. A list of specific projects that were funded and projects that were not funded within mental health, for both PTSD-related and non-PTSD related areas. 5. We request that Research Service continue to provide the committee with the aforementioned data on an annual basis either directly or through MHSH in future years. (Priority 1)		X	
COMMENTS: VA Research and Development is in the midst of important change at the time of this writing such that it is no longer clear that the Committee's goals can be reached by identifying PTSD as a Designated Research Area. Progress towards the Committee's research aims will be followed in terms of the Committee's recommendation that PTSD be identified as a VA research priority as stated in this report.				

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RESEARCH SECTION		Status Due Date		
DOMAIN - None Cited **RECOMMENDATION (S) 29**	**OBJECTIVE**	**M**	**NM**	**P**
Recommendation 29: VA should increase funding for post-doctoral research positions in PTSD (VA recently developed a clinical post-doctoral program for specialization in PTSD; however, development of a research emphasis program would ensure the continued scientific expertise of VA researchers).	The Committee requests that: 1. The proposed meeting between MHSHG, OAA, and NCPTSD be convened to take up this issue and that we receive a report of their progress. 2. The Committee receive a report of the number of MIRECC post-doctoral fellows who identified PTSD as a primary research focus (source: MIRECC Hub Site at Palo Alto, VAMC). 3. MHSHG and OAA explore the promotion and funding of PTSD Research fellowships outside of the MIRECCs mechanism as well. (Priority II)		X	

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COMMENTS: These reports have not been received and no new information has been received from MHSHG or OAA. This issue could be turned over to the Joint DoD/VA Council on Post Deployment Mental Health called for in this report.

RESEARCH SECTION		Status Due Date		
DOMAIN - None Cited **RECOMMENDATION (S) 30**	**OBJECTIVE**	**M**	**NM**	**P**
Recommendation 30: **VA should expand funding to increase the number of MIRECCs with special solicitations for MIRECCs aimed at PTSD-specific research including psychobiological effects of trauma across the life span and/or a MIRECC specifically focused on collaboration with DoD on PTSD. Such MIRECC proposals should be reviewed with this Committee.**	The Committee requests a summary of the stated research emphasis areas of pending MIRECC proposals, including letters of interest recently solicited in anticipation of new MIRECC funding. **(Priority II)**		X	

COMMENTS: Funds for two new MIRECCs were released this year. In the Request for Proposals issued, it was noted that one of the MIRECCs was earmarked for suicide prevention. There was no mention of PTSD as a special priority for MIRECC funding. The Committee has not been involved in review of the pending MIRECC proposals.

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RESEARCH SECTION		Status Due Date		
DOMAIN 7 – Goals for collaboration, coordination, and expansion of PTSD research. **RECOMMENDATION (S) 31-32**	**OBJECTIVE**	**N**	**NM**	**P**
Recommendation 31: The Committee should work with The National Center for PTSD, MIRECCs, and Health Services Centers of Excellence to enhance communication, collaboration, and coordination in PTSD research across VA, and between VA and other Federal and non-Federal agencies. **Recommendation 32:** The Committee should work with The National Center for PTSD, MIRECCs, Health Services Centers of Excellence and other Federal and non-Federal agencies to enhance communication, collaboration and coordination on PTSD research goals.	In order to meet the endorsed recommendation that PTSD researchers in the VA improve communication and collaboration, the Committee requests that the Under Secretary convene a VA Traumatic Stress Research Summit. This meeting, to be organized by the NC-PTSD, will provide senior researchers with an opportunity to come together and will encourage new, more junior investigators to specialize in PTSD research. The rationale for the Research Summit and suggestions for its organization are as follows: 1. The PTSD Summit would provide VA with an opportunity to educate staff throughout VA, as well as from other branches of the government (including members of Congress and their staffs), about the consequences of traumatic stress and about VA's unique expertise in this critically important area. It would provide an excellent meeting place for VA staff to interact with experts from DoD, other Federal and Non-Federal agencies including Veterans Service Organizations (VSOs), the American Red Cross, the Salvation Army, and other important stakeholders. 2. The VA PTSD summit could be an excellent venue for stimulating collaboration between the NC-PTSD and the National Center for War-Related Illnesses. 3. The Committee will work with the National Center for PTSD and MIRECCs to identify themes for future Research Summits. The Committee further recommends that VA provide travel funds to enable junior investigators to attend. NC-PTSD should develop a plan to set up mentoring relationships between junior and senior investigators attending the Summit. (Priority II)		X	
COMMENTS: VISN 16's MIRECC, in coordination with EES, held a PTSD Conference entitled "Bringing PTSD Research to Practice in the VA" on January 13, 2003 and will hold a second PTSD Conference in July 2004. There has been no movement forward on a PTSD Summit as outlined in this domain. The Committee considers progress in this area to be an important component of VA's recognition of PTSD and Post Deployment Mental Health as a Research Priority as called for in this report. The Summit could be convened by the Joint DoD/VA Council on Post Deployment Mental Health called for in this report.				

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VETERANS BENEFITS SECTION		Status Due Date		
DOMAIN 8 – Assuring equal access and efficient service for veterans filing claims for service connection for PTSD across VA. **RECOMMENDATION (S) 33-34**	**OBJECTIVE**	**N**	**N M**	**P**
Recommendation 33: VBA should collect appropriate data on grants/denials and percentage of service connection for PTSD evaluations by each Regional Office. VA should closely monitor and seek to develop new policy and training initiatives should the data demonstrate significant disparity across the system. **Recommendation 34**: VBA should, if feasible, gather office-by-office data about variability in: (a) time from date of filing a claim to date of service connection; and (b) rates of service connection across different populations (including different stressor categories, genders, and ethnic groups).	The Committee recommends that a meeting take place between Committee members and representatives of VBA for the purpose of developing a set of useful assessment measures. These measures might include information about: (a) the total number of disability claims filed; (b) the number of claims specifically filed for PTSD; (c) the number (and percent of disability awarded) of claims approved for the general veteran population and for PTSD, respectively; (d) the percentage of claims filed for PTSD in which the stressor was confirmed; (e) the percentage of claimants for whom the diagnosis of PTSD was confirmed; (f) the number and percentage of PTSD claims that were appealed; (g) the number of appealed claims for PTSD that were overturned; and (h) the percent increase in disability awarded in those successfully appealed claims. The Committee would also be interested in information about the average time necessary to process PTSD claims and whether it differs from the average time necessary to process other claims. Providing a breakdown of the aforementioned data by gender and ethnicity is highly desirable. Whenever possible, data should be examined at the national level and compared between individual Regional Offices. (Priority I)		X	
COMMENTS: VBA, MHSHG, and the National Center for PTSD are to be commended for the development and implementation of the Best Practice Manual for PTSD Compensation and Pension Examinations. The Committee will work with VBA and MHSHG to convene a meeting at which data on the impact of the Best Practice Manual can be reviewed and at which issues relating to C&P examinations of OEF/OIF combat veterans can be considered.				

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VETERANS BENEFITS SECTION		Status Due Date		
DOMAIN – None Cited **RECOMMENDATION (S) 35**	**OBJECTIVE**	**N**	**NM**	**P**
Recommendation 35: VA should support a research study of the quality of PTSD Compensation and Pension (C&P) exams. Any review of exam quality should include exams done by VA staff, by QTC contract examiners, and by independent fee-basis examiners hired by local medical facilities.	The Committee requests a report on VBA's assessments in this area (as referred to in the Under Secretary's response to this Recommendation) and a report from VBA on the feasibility of pursuing further exploration of the quality of PTSD examinations. A "Best Practices" guideline for conducting PTSD C&P examinations will be released in by fourth quarter FY 2002, reflecting the combined efforts of the National Center for PTSD, the Northwest MIRECC, and VBA. The Committee requests that VBA, MHSHG, and Research Service develop a preliminary plan, in collaboration with the architects of this guideline, for its implementation and testing through research initiatives. Specifically, we recommend that Research Service support proposals aimed at studying: (a) the current status and quality of PTSD disability evaluations; and (b) the implementation of standardized, evidence-based practices in the PTSD assessment process. (Prioritty I)		**X**	
COMMENTS: The Committee believes that data based on implementation to date of the Best Practice Manual for PTSD C&P Exams would be of great value to VA in general and of specific and timely value in regard to new combat veterans of OEF/OIF. The meeting between representatives of the Committee, MHSHG, and VBA recommended in the comments regarding Recommendation 34 could also address the current value of a research study on the quality of PTSD C&P examinations. This study might include a special focus on examination of new combat veterans.				

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VETERANS BENEFITS SECTION		Status Due Date		
DOMAIN – None Cited **RECOMMENDATION (S) 36**	OBJECTIVE	**M**	**N M**	**P**
Recommendation 36: VBA and VHA should resolve Global Assessment of Functioning (GAF) issues through joint research, policy, and training initiatives. GAF issues in relation to disability claims were also addressed in a February 7, 2001, joint VHA/VBA satellite broadcast on the PTSD Compensation and Pension Examination.	The Committee recommends that VBA and VHA prepare and implement a policy statement advising Regional Offices of the following: 1. Raters are to not use information from GAF scores in disability rating decisions for veterans filing a claim for PTSD. That is, raters should understand and adhere to a policy by which judgments about PTSD symptom severity and the claimant's social and occupational impairment are to be based on sources of information other than GAF scores (e.g., descriptive information contained in reports by examiners, medical records, and vocational assessments). 2. Moreover, standing policy that prohibits requests for "partitioned" GAF scores (i.e., separate GAF scores for different disorders) from examiners needs to be assertively implemented and publicized across Regional Offices. 3. Under no circumstances are raters to render a rating decision of percent of disability based on one-to-one correspondence with a GAF score (e.g., rating a claimant at the 50 percent level simply because a GAF score of 50 has been rendered). Successful implementation of the soon-to-be published "Best Practices" guideline for conducting PTSD C&P examinations (as noted in the above discussion of Recommendation 35) will provide VBA raters with alternative sources of information of higher quality in the service of discouraging the current practice of over-reliance on GAF scores. (Priority I)	**X**		
COMMENTS: Item closed based on action taken in the development and implementation of the Best Practice Manual for PTSD C&P Examinations.				

Attachment A
UNDER SECRETARY FOR HEALTH
SPECIAL COMMITTEE
ON
POST TRAUMATIC STRESS DISORDER (PTSD) 2004 Report

VETERANS BENEFITS SECTION		Status Due Date		
DOMAIN – None Cited **RECOMMENDATION (S) 37**	OBJECTIVE	**M**	**N M**	**P**
Recommendation 37: VHA should establish procedures and controls that ensure the proper management of claims folders sent to them, their appropriate review by examiners, and their prompt return to Regional Offices.	The Committee requests that VHA provide a description of current procedures and controls to safeguard and manage claims folders. An update on the status of plans for implementation of electronic claims file transfer is also requested. (Priority II)	X		
COMMENTS: Item closed.				

Attachment B
VA Funded PTSD Projects - FY 2003

Station	Investigator	FundDesc	FundingExp	Title	MeSH
558 Durham, NC	Beckham, Jean	9003 Merit Review (CC 103)	$91,000	Tobacco Use in Smokers: Effect of Trauma Exposure & PTSD	SUBSTANCE ABUSE * STRESS DISORDERS, POST-TRAUMATIC * ANXIETY * * *
459 Honolulu, HI	Bracha, H. Stefan	9003 Merit Review (CC 103)	$73,479	Clinical Research Biomarkers for Estimating Early Stress	STRESS DISORDERS, POST-TRAUMATIC * NEUROBIOLOGY * DENTAL ENAMEL HYPOPLASIA * BIOLOGICAL MARKERS * AUTONOMIC NERVOUS SYSTEM *
508 Decatur, GA	Bremner, James	9003 Merit Review (CC 103)	$69,288	Memory and the Hippocampus in Vietnam Twins with PTSD	VIETNAM * TWINS * STRESS DISORDERS, POST-TRAUMATIC * MEMORY * MAGNETIC RESONANCE IMAGING * HIPPOCAMPUS
679 Tuscaloosa, AL	Davis, Lori	9003 Merit Review (CC 103)	$76,983	Divalproex Sodium in the Treatment of PTSD: A Placebo-Controlled Study	STRESS DISORDERS, POST-TRAUMATIC * GAMMA-AMINOBUTYRIC ACID * CLINICAL TRIALS * CENTRAL NERVOUS SYSTEM * *
673 Tampa, FL	Diamond, David	9003 Merit Review (CC 103)	$252,765	Neuroendocrine Basis of Stress Effects on Memory and Brain Plasticity	STRESS DISORDERS, POST-TRAUMATIC * NEURONAL PLASTICITY * MEMORY DISORDERS * HIPPOCAMPUS * BRAIN *
608 Manchester, NH	Gilbertson, Mark	9003 Merit Review (CC 103)	$126,900	Structural Brain MRI and Neurocognitive Function in Female Nurse Vietnam Veterans	WOMEN * STRESS DISORDERS, POST-TRAUMATIC * NURSES * NEUROPSYCHOLOGY * MAGNETIC RESONANCE IMAGING * HIPPOCAMPUS
526 Bronx, NY	Golier, Julia	9003 Merit Review (CC 103)	$56,750	HPA Axis Alterations in PTSD: A Comparison of Gulf War and Vietnam Veterans	STRESS DISORDERS, POST-TRAUMATIC * GLUCOCORTICOIDS * CORTICOTROPIN * *
664 San Diego, CA	Hauger, Richard	9003 Merit Review (CC 103)	$152,362	CRF1 Receptor, GRKs, Arrestins: Stress Sensitization and Mood Disorders	STRESS DISORDERS, POST-TRAUMATIC * PSYCHOTIC DISORDERS * CORTICOTROPIN-RELEASING HORMONE * BRAIN * BIPOLAR DISORDER *
662 San Francisco, CA	Kim, Hubert	9003 Merit Review (CC 103)	$30,605	Chondrocyte Apoptosis in Post-Traumatic Arthritis	STRESS DISORDERS, POST-TRAUMATIC * FRACTURES * CARTILAGE, ARTICULAR * ARTHRITIS * APOPTOSIS *
608 Manchester, NH	Metzger, Linda	9003 Merit Review (CC 103)	$204,624	ERP Abnormalities in Female Nurse and Male Combat Vietnam Veterans with PTSD	WOMEN * STRESS DISORDERS, POST-TRAUMATIC * SEX FACTORS * PSYCHOPHYSIOLOGY * NURSES * EVENT-RELATED POTENTIALS, P300
523 Boston, MA	Niles, Barbara	9003 Merit Review (CC 103)	$24,500	IRB #1153: PTSD and Chronic Pain: Longitudinal Evaluation of Mutual Maintenance	STRESS DISORDERS, POST-TRAUMATIC * LONGITUDINAL STUDIES * BEHAVIORAL SYMPTOMS * * *
608 Manchester, NH	Orr, Scott	9003 Merit Review (CC 103)	$131,802	Beta-Adrenergic Blockade of Increased Conditionability in PTSD	STRESS DISORDERS, POST-TRAUMATIC * CONDITIONING (PSYCHOLOGY) * ADRENERGIC BETA-ANTAGONISTS * * *
561 East Orange, NJ	Peckerman, Arnold	9003 Merit Review (CC 103)	$65,112	Cardiovascular Hyporeactivity and Fatiguing Illness in Gulf War Veterans	STRESS DISORDERS, POST-TRAUMATIC * PERSIAN GULF SYNDROME * FATIGUE * DEPRESSION * AUTONOMIC NERVOUS SYSTEM *
689 West Haven, CT	Rasmusson, Ann	9003 Merit Review (CC 103)	$101,300	HPA Axis Reactivity in Men and Women with Chronic PTSD	STRESS DISORDERS, POST-TRAUMATIC * PITUITARY GLAND * PHARMACY * ADRENAL GLANDS * *
539 Cincinnati, OH	Richtand, Neil	9003 Merit Review (CC 103)	$136,882	Role of D3 Dopamine Receptor in Behavior	SUBSTANCE-RELATED DISORDERS * STRESS DISORDERS, POST-TRAUMATIC * RECEPTORS, DOPAMINE * PSYCHOTIC DISORDERS * AMPHETAMINE *

Attachment B
VA Funded PTSD Projects - FY 2003

Station	Investigator	FundDesc	FundingExp	Title	MeSH
642 Philadelphia, PA	Ross, Richard	9003 Merit Review (CC 103)	$107,732	Effects of Stress on Sleep: Limbic Mechanisms	STRESS DISORDERS, POST-TRAUMATIC * SLEEP, REM * CORTICOTROPIN-RELEASING HORMONE * AMYGDALA * *
689 West Haven, CT	Southwick, Steven	9003 Merit Review (CC 103)	$50,850	Guanfacine for the Treatment of PTSD	STRESS DISORDERS, POST-TRAUMATIC * PHARMACOLOGY * GUANFACINE * DRUG THERAPY * *
664 San Diego, CA	Stein, Murray	9003 Merit Review (CC 103)	$133,803	Neurobiology of Severe Psychological Trauma in Women	WOMEN'S HEALTH * TRAUMATOLOGY * STRESS DISORDERS, POST-TRAUMATIC * * *
629 New Orleans, LA	Vasterling, Jennifer	9003 Merit Review (CC 103)	$37,700	Follow-up of Psychological and Neurocognitive Gulf War Outcome: Relation to Stress	STRESS DISORDERS, POST-TRAUMATIC * NEUROPSYCHOLOGY * MEMORY * * *
526 Bronx, NY	Yehuda, Rachel	9003 Merit Review (CC 103)	$135,000	Analysis of Hippocampal Volume in Aging Combat Veterans with PTSD	STRESS DISORDERS, POST-TRAUMATIC * NEUROENDOCRINOLOGY * HYDROCORTISONE * HIPPOCAMPUS * AGING *
544 Columbia, SC	Powell, Donald	9006 Special Research Initiatives (CC 106)	$20,826	Associative Learning in Veterans with and Without Combat Experience	STRESS DISORDERS, POST-TRAUMATIC * STARTLE REACTION * CONDITIONING (PSYCHOLOGY) * * *
663 Seattle, WA	Raskind, Murray	9006 Special Research Initiatives (CC 106)	$70,213	Prazosin Treatment for Combat Trauma PTSD Nightmares and Sleep Disturbance	STRESS DISORDERS, POST-TRAUMATIC * SLEEP DISORDERS * PRAZOSIN * * *
539 Cincinnati, OH	Wang, Zhewu	9006 Special Research Initiatives (CC 106)	$356	Investigation of Genetic Predisposition to Stress Related Psychopathology	STRESS DISORDERS, POST-TRAUMATIC * GENETICS * CORTICOTROPIN-RELEASING HORMONE * * *
506 Ann Arbor, MI	Liberzon, Israel	9008 Career Development (CC 108)	$160,147	Neurobiological Predictors of Stress-Related Disorders After Major Surgery: A Prospective Study	VASCULAR SURGICAL PROCEDURES * STRESS DISORDERS, POST-TRAUMATIC * CORTISONE * * *
405 White River Junction, VT	Monson, Candice	9008 Career Development (CC 108)	$87,800	Cognitive Processing Therapy (CPT) for Post-Traumatic Stress Disorder (PTSD)	STRESS DISORDERS, POST-TRAUMATIC * PSYCHOTHERAPY * MENTAL HEALTH * CLINICAL TRIALS * *
540 Clarksburg, WV	Bartsch, Thomas	9009 Other Designated Research (CC 109)	$2,950	Assessing the Effect of a Family Education Video Tape on the Severity of Veterans' Ptsd and Selected Comorbidities	VIDEO RECORDING * STRESS DISORDERS, POST-TRAUMATIC * FAMILY * AFTERCARE * *
570 Fresno, CA	Hierholzer, Robert	9009 Other Designated Research (CC 109)	$32,392	Comparison of Antihypertensive Medication and Placebo in the Treatment of Patients with Ptsd	STRESS DISORDERS, POST-TRAUMATIC * GUANFACINE * ANTIHYPERTENSIVE AGENTS * * *
534 Charleston, SC	Lorberbaum, Jeffrey	9009 Other Designated Research (CC 109)	$3,000	Functional MRI in Patients with Post-Traumatic Stress Disorder and Non-Ill Controls	STRESS DISORDERS, POST-TRAUMATIC * MAGNETIC RESONANCE IMAGING * BRAIN MAPPING * * *
640 Palo Alto, CA	Frayne, Susan	9024 Health Services R&D (Prog 824)	$188,077	RCD Level 1	STRESS DISORDERS, POST-TRAUMATIC * QUALITY ASSURANCE, HEALTH CARE * OUTCOME ASSESSMENT (HEALTH CARE) * MENTAL DISORDERS * DEPRESSION * AMBULATORY CARE
534 Charleston, SC	Magruder, Kathryn	9024 Health Services R&D (Prog 824)	$25,000	Prevalence and Recognition of PTSD in VA Primary Care	STRESS DISORDERS, POST-TRAUMATIC * PRIMARY HEALTH CARE * PREVALENCE * * *
640 Palo Alto, CA	Rosen, Craig	9024 Health Services R&D (Prog 824)	$2,610	Feasibility of Telephone Case Monitoring for Veterans with PTSD	TELEPHONE * STRESS DISORDERS, POST-TRAUMATIC * MONITORING, PHYSIOLOGIC * * *
618 Minneapolis, MN	Sayer, Nina	9024 Health Services R&D (Prog 824)	$112,201	Perceptions of the Compensation & Pension Process for PTSD: Symptoms and Service Utilization	STRESS DISORDERS, POST-TRAUMATIC * PERCEPTION * AFFECTIVE SYMPTOMS * * *

Attachment B
VA Funded PTSD Projects - FY 2003

Station	Investigator	FundDesc	FundingExp	Title	MeSH
539 Cincinnati, OH	Baker, Dewleen	9025 Cooperative Studies (Prog 825)	$85,896	A Randomized Clinical Trial of Cognitive-Behavioral Treatment for PTSD in Women	WOMEN * STRESS DISORDERS, POST-TRAUMATIC * MILITARY PERSONNEL * COGNITIVE THERAPY * CLINICAL TRIALS * BEHAVIOR THERAPY
501 Albuquerque, NM	Castillo, Diane	9025 Cooperative Studies (Prog 825)	$51,245	A Randomized Clinical Trial of Cognitive-Behavioral Treatment for PTSD in Women	WOMEN * STRESS DISORDERS, POST-TRAUMATIC * MILITARY PERSONNEL * COGNITIVE THERAPY * CLINICAL TRIALS * BEHAVIOR THERAPY
405 White River Junction, VT	Friedman, Matthew	9025 Cooperative Studies (Prog 825)	$173,379	A Randomized Clinical Trial of Cognitive-Behavioral Treatment for PTSD in Women	WOMEN * STRESS DISORDERS, POST-TRAUMATIC * MILITARY PERSONNEL * COGNITIVE THERAPY * CLINICAL TRIALS * BEHAVIOR THERAPY
512 Baltimore, MD	Gearon, Jean	9025 Cooperative Studies (Prog 825)	$51,828	A Randomized Clinical Trial of Cognitive-Behavioral Treatment for PTSD in Women	WOMEN * STRESS DISORDERS, POST-TRAUMATIC * MILITARY PERSONNEL * COGNITIVE THERAPY * CLINICAL TRIALS * BEHAVIOR THERAPY
554 Denver, CO	Haug, Rodney	9025 Cooperative Studies (Prog 825)	$49,342	A Randomized Clinical Trial of Cognitive-Behavioral Treatment for PTSD in Women	WOMEN * STRESS DISORDERS, POST-TRAUMATIC * MILITARY PERSONNEL * COGNITIVE THERAPY * CLINICAL TRIALS * BEHAVIOR THERAPY
516 Bay Pines, FL	Hayman, Peter	9025 Cooperative Studies (Prog 825)	$71,478	A Randomized Clinical Trial of Cognitive-Behavioral Treatment for PTSD in Women	WOMEN * STRESS DISORDERS, POST-TRAUMATIC * MILITARY PERSONNEL * COGNITIVE THERAPY * CLINICAL TRIALS * BEHAVIOR THERAPY
541 Cleveland, OH	Liebling, David	9025 Cooperative Studies (Prog 825)	$54,454	A Randomized Clinical Trial of Cognitive-Behavioral Treatment for PTSD in Women	WOMEN * STRESS DISORDERS, POST-TRAUMATIC * MILITARY PERSONNEL * COGNITIVE THERAPY * CLINICAL TRIALS * BEHAVIOR THERAPY
523 Boston, MA	Orsillo, Susan	9025 Cooperative Studies (Prog 825)	$71,478	A Randomized Clinical Trial of Cognitive-Behavioral Treatment for PTSD in Women	WOMEN * STRESS DISORDERS, POST-TRAUMATIC * MILITARY PERSONNEL * COGNITIVE THERAPY * CLINICAL TRIALS * BEHAVIOR THERAPY
648 Portland, OR	Powch, Irene	9025 Cooperative Studies (Prog 825)	$71,431	A Randomized Clinical Trial of Cognitive-Behavioral Treatment for PTSD in Women	WOMEN * STRESS DISORDERS, POST-TRAUMATIC * MILITARY PERSONNEL * COGNITIVE THERAPY * CLINICAL TRIALS * BEHAVIOR THERAPY
508 Decatur, GA	Quarles, Shirley	9025 Cooperative Studies (Prog 825)	$72,880	A Randomized Clinical Trial of Cognitive-Behavioral Treatment for PTSD in Women	WOMEN * STRESS DISORDERS, POST-TRAUMATIC * MILITARY PERSONNEL * COGNITIVE THERAPY * CLINICAL TRIALS * BEHAVIOR THERAPY
405 White River Junction, VT	Schnurr, Paula	9025 Cooperative Studies (Prog 825)	$205,376	A Randomized Clinical Trial of Cognitive-Behavioral Treatment for PTSD in Women	WOMEN * STRESS DISORDERS, POST-TRAUMATIC * MILITARY PERSONNEL * COGNITIVE THERAPY * CLINICAL TRIALS * BEHAVIOR THERAPY
650 Providence, RI	Shea, M. Tracie	9025 Cooperative Studies (Prog 825)	$180,083	A Randomized Clinical Trial of Cognitive-Behavioral Treatment for PTSD in Women	WOMEN * STRESS DISORDERS, POST-TRAUMATIC * MILITARY PERSONNEL * COGNITIVE THERAPY * CLINICAL TRIALS * BEHAVIOR THERAPY
549 Dallas, TX	Suris, Alina	9025 Cooperative Studies (Prog 825)	$66,859	A Randomized Clinical Trial of Cognitive-Behavioral Treatment for PTSD in Women	WOMEN * STRESS DISORDERS, POST-TRAUMATIC * MILITARY PERSONNEL * COGNITIVE THERAPY * CLINICAL TRIALS * BEHAVIOR THERAPY

Attachment B
VA Funded PTSD Projects - FY 2003

Station	Investigator	FundDesc	FundingExp	Title	MeSH
546 Miami, FL	Taylor, Andrew	9025 Cooperative Studies (Prog 825)	$148,750	Risperidone Treatment for Chronic Post Traumatic Stress Disorder	STRESS DISORDERS, POST-TRAUMATIC * RISPERIDONE * PSYCHOMOTOR AGITATION * HALLUCINATIONS * *
525 Brockton, MA	Toomey, Rosemary	9025 Cooperative Studies (Prog 825)	$3,012	National Health Survey of Persian Gulf Veterans and Their Families	STRESS DISORDERS, POST-TRAUMATIC * PERSIAN GULF SYNDROME * HEALTH STATUS * FATIGUE SYNDROME, CHRONIC * CROSS-SECTIONAL STUDIES *
629 New Orleans, LA	Uddo, Madeline	9025 Cooperative Studies (Prog 825)	$71,478	A Randomized Clinical Trial of Cognitive-Behavioral Treatment for PTSD in Women	WOMEN * STRESS DISORDERS, POST-TRAUMATIC * MILITARY PERSONNEL * COGNITIVE THERAPY * CLINICAL TRIALS * BEHAVIOR THERAPY
			$4,193,978		
558 Durham, NC	Beckham, Jean	9103 National Cancer Institute	$70,000	Smoking and Anxiety in Postraumatic Stress Disorder	STRESS DISORDERS, POST-TRAUMATIC * NICOTINE * ANXIETY * * *
534 Charleston, SC	Myrick, Donald Lahugh	9127 Natl Inst on Alcohol Abuse & Alcoholism	$84,499	Posttraumatic Stress Disorder and Alcoholism: The Role of the HPA Axis	STRESS DISORDERS, POST-TRAUMATIC * AXIS * ALCOHOLISM * * *
584 Iowa City, IA	Buckwalter, Joseph	9129 Natl Inst on Arth, Musculo & Skin Dis	$929,545	Pathogenesis - Prevention of Post-Traumatic OA	STRESS DISORDERS, POST-TRAUMATIC * PREVENTIVE MEDICINE * CAUSALITY * * *
523 Boston, MA	Buckley, Todd	9133 Natl Inst on Drug Abuse	$10,866	Nicotine, Attention, and Conditioned Arousal in PTSD	STRESS DISORDERS, POST-TRAUMATIC * NICOTINE * ATTENTION * AROUSAL * *
671 San Antonio, TX	Casada, John	9133 Natl Inst on Drug Abuse	$145,589	Emotional Control of Sedative Self Medication in PTSD	STRESS DISORDERS, POST-TRAUMATIC * SELF MEDICATION * ANXIETY * ALCOHOLISM * *
689 West Haven, CT	Petrakis, Ismene	9133 Natl Inst on Drug Abuse	$218,147	Naltrexone & Antidepressants in Alcoholics with PTSD and/or Depressive Disorders	STRESS DISORDERS, POST-TRAUMATIC * PAROXETINE * NALTREXONE * DESIPRAMINE * DEPRESSIVE DISORDER * ANTIDEPRESSIVE AGENTS
558 Durham, NC	Beckham, Jean	9135 Natl Inst on Mental Health	$140,000	Hostility, PTSD, and Physical Health Risk Factors in Women	STRESS DISORDERS, POST-TRAUMATIC * RISK FACTORS * HOSTILITY * * *
523 Boston, MA	Buckley, Todd	9135 Natl Inst on Mental Health	$12,974	IRB #1580 - CBT for PTSD Among Public Sector Consumers	STRESS DISORDERS, POST-TRAUMATIC * PUBLIC SECTOR * BEHAVIOR THERAPY * * *
534 Charleston, SC	Frueh, Bartley	9135 Natl Inst on Mental Health	$35,000	Disability Benefits and Service Use	STRESS DISORDERS, POST-TRAUMATIC * MENTAL HEALTH * DISABILITY EVALUATION * * *
534 Charleston, SC	Frueh, Bartley	9135 Natl Inst on Mental Health	$185,000	Telepsychiatry Service Delivery to Trauma Victims	STRESS DISORDERS, POST-TRAUMATIC * PSYCHOTHERAPY * DEPRESSION * * *
534 Charleston, SC	Hamner, Mark	9135 Natl Inst on Mental Health	$100,167	Telepsychiatry Service Delivery to Trauma Victims	STRESS DISORDERS, POST-TRAUMATIC * PSYCHOTHERAPY * DEPRESSION * * *
523 Boston, MA	Kaloupek, Danny	9135 Natl Inst on Mental Health	$76,037	IRB #1122: Studies of Sustained and Selective Attention in PTSD	STRESS DISORDERS, POST-TRAUMATIC * PSYCHOPHYSIOLOGY * EVOKED POTENTIALS * ATTENTION * *
523 Boston, MA	Keane, Terence	9135 Natl Inst on Mental Health	$285,383	Treating Torture & Related Trauma in Bosnian Regugees	TRAUMA CENTERS * TORTURE * STRESS DISORDERS, POST-TRAUMATIC * * *
523 Boston, MA	Keane, Terence	9135 Natl Inst on Mental Health	$166,343	Postdoctoral Training in PTSD	TRAINING SUPPORT * STRESS DISORDERS, POST-TRAUMATIC * PSYCHOLOGY * * *
523 Boston, MA	Keane, Terence	9135 Natl Inst on Mental Health	$490,882	Project Welcome	TRAUMA CENTERS * STRESS DISORDERS, POST-TRAUMATIC * REFUGEES * * *
523 Boston, MA	Litz, Brett	9135 Natl Inst on Mental Health	$100,000	The Parameters of Emotional Processing in PTSD	WOMEN * STRESS DISORDERS, POST-TRAUMATIC * HISPANIC AMERICANS * * *
523 Boston, MA	Litz, Brett	9135 Natl Inst on Mental Health	$225,000	IRB #1564: Breif Cognitive-behavioral Treatment for Victims of Mass Violence	VIOLENCE * STRESS DISORDERS, POST-TRAUMATIC * BEHAVIOR THERAPY * * *
662 San Francisco, CA	Marmar, Charles	9135 Natl Inst on Mental Health	$722,251	Prospective Study of Posttraumatic Stress in New Police Officers	STRESS DISORDERS, POST-TRAUMATIC * PROSPECTIVE STUDIES * POLICE * * *

Attachment B
VA Funded PTSD Projects - FY 2003

Station	Investigator	FundDesc	FundingExp	Title	MeSH
546 Miami, FL	Taylor, Andrew	9025 Cooperative Studies (Prog 825)	$148,750	Risperidone Treatment for Chronic Post Traumatic Stress Disorder	STRESS DISORDERS, POST-TRAUMATIC * RISPERIDONE * PSYCHOMOTOR AGITATION * HALLUCINATIONS * *
525 Brockton, MA	Toomey, Rosemary	9025 Cooperative Studies (Prog 825)	$3,012	National Health Survey of Persian Gulf Veterans and Their Families	STRESS DISORDERS, POST-TRAUMATIC * PERSIAN GULF SYNDROME * HEALTH STATUS * FATIGUE SYNDROME, CHRONIC * CROSS-SECTIONAL STUDIES *
629 New Orleans, LA	Uddo, Madeline	9025 Cooperative Studies (Prog 825)	$71,478	A Randomized Clinical Trial of Cognitive-Behavioral Treatment for PTSD in Women	WOMEN * STRESS DISORDERS, POST-TRAUMATIC * MILITARY PERSONNEL * COGNITIVE THERAPY * CLINICAL TRIALS * BEHAVIOR THERAPY
			$4,193,978		
558 Durham, NC	Beckham, Jean	9103 National Cancer Institute	$70,000	Smoking and Anxiety in Postraumatic Stress Disorder	STRESS DISORDERS, POST-TRAUMATIC * NICOTINE * ANXIETY * * *
534 Charleston, SC	Myrick, Donald Lahugh	9127 Natl Inst on Alcohol Abuse & Alcoholism	$84,499	Posttraumatic Stress Disorder and Alcoholism: The Role of the HPA Axis	STRESS DISORDERS, POST-TRAUMATIC * AXIS * ALCOHOLISM * * *
584 Iowa City, IA	Buckwalter, Joseph	9129 Natl Inst on Arth, Musculo & Skin Dis	$929,545	Pathogenesis - Prevention of Post-Traumatic OA	STRESS DISORDERS, POST-TRAUMATIC * PREVENTIVE MEDICINE * CAUSALITY * * *
523 Boston, MA	Buckley, Todd	9133 Natl Inst on Drug Abuse	$10,866	Nicotine, Attention, and Conditioned Arousal in PTSD	STRESS DISORDERS, POST-TRAUMATIC * NICOTINE * ATTENTION * AROUSAL * *
671 San Antonio, TX	Casada, John	9133 Natl Inst on Drug Abuse	$145,589	Emotional Control of Sedative Self Medication in PTSD	STRESS DISORDERS, POST-TRAUMATIC * SELF MEDICATION * ANXIETY * ALCOHOLISM * *
689 West Haven, CT	Petrakis, Ismene	9133 Natl Inst on Drug Abuse	$218,147	Naltrexone & Antidepressants in Alcoholics with PTSD and/or Depressive Disorders	STRESS DISORDERS, POST-TRAUMATIC * PAROXETINE * NALTREXONE * DESIPRAMINE * DEPRESSIVE DISORDER * ANTIDEPRESSIVE AGENTS
558 Durham, NC	Beckham, Jean	9135 Natl Inst on Mental Health	$140,000	Hostility, PTSD, and Physical Health Risk Factors in Women	STRESS DISORDERS, POST-TRAUMATIC * RISK FACTORS * HOSTILITY * * *
523 Boston, MA	Buckley, Todd	9135 Natl Inst on Mental Health	$12,974	IRB #1580 - CBT for PTSD Among Public Sector Consumers	STRESS DISORDERS, POST-TRAUMATIC * PUBLIC SECTOR * BEHAVIOR THERAPY * * *
534 Charleston, SC	Frueh, Bartley	9135 Natl Inst on Mental Health	$35,000	Disability Benefits and Service Use	STRESS DISORDERS, POST-TRAUMATIC * MENTAL HEALTH * DISABILITY EVALUATION * * *
534 Charleston, SC	Frueh, Bartley	9135 Natl Inst on Mental Health	$185,000	Telepsychiatry Service Delivery to Trauma Victims	STRESS DISORDERS, POST-TRAUMATIC * PSYCHOTHERAPY * DEPRESSION * * *
534 Charleston, SC	Hamner, Mark	9135 Natl Inst on Mental Health	$100,167	Telepsychiatry Service Delivery to Trauma Victims	STRESS DISORDERS, POST-TRAUMATIC * PSYCHOTHERAPY * DEPRESSION * * *
523 Boston, MA	Kaloupek, Danny	9135 Natl Inst on Mental Health	$76,037	IRB #1122: Studies of Sustained and Selective Attention in PTSD	STRESS DISORDERS, POST-TRAUMATIC * PSYCHOPHYSIOLOGY * EVOKED POTENTIALS * ATTENTION * *
523 Boston, MA	Keane, Terence	9135 Natl Inst on Mental Health	$285,383	Treating Torture & Related Trauma in Bosnian Regugees	TRAUMA CENTERS * TORTURE * STRESS DISORDERS, POST-TRAUMATIC * * *
523 Boston, MA	Keane, Terence	9135 Natl Inst on Mental Health	$166,343	Postdoctoral Training in PTSD	TRAINING SUPPORT * STRESS DISORDERS, POST-TRAUMATIC * PSYCHOLOGY * * *
523 Boston, MA	Keane, Terence	9135 Natl Inst on Mental Health	$490,882	Project Welcome	TRAUMA CENTERS * STRESS DISORDERS, POST-TRAUMATIC * REFUGEES * * *
523 Boston, MA	Litz, Brett	9135 Natl Inst on Mental Health	$100,000	The Parameters of Emotional Processing in PTSD	WOMEN * STRESS DISORDERS, POST-TRAUMATIC * HISPANIC AMERICANS * * *
523 Boston, MA	Litz, Brett	9135 Natl Inst on Mental Health	$225,000	IRB #1564: Breif Cognitive-behavioral Treatment for Victims of Mass Violence	VIOLENCE * STRESS DISORDERS, POST-TRAUMATIC * BEHAVIOR THERAPY * * *
662 San Francisco, CA	Marmar, Charles	9135 Natl Inst on Mental Health	$722,251	Prospective Study of Posttraumatic Stress in New Police Officers	STRESS DISORDERS, POST-TRAUMATIC * PROSPECTIVE STUDIES * POLICE * * *

Attachment B
VA Funded PTSD Projects - FY 2003

Station	Investigator	FundDesc	FundingExp	Title	MeSH
662 San Francisco, CA	Marmar, Charles	9135 Natl Inst on Mental Health	$45,789	CBT for PTSD in Disaster Relief Workers	STRESS DISORDERS, POST-TRAUMATIC * RELIEF WORK * DISASTERS * COGNITIVE THERAPY * *
405 White River Junction, VT	McDonagh-Coyle, Annmarie	9135 Natl Inst on Mental Health	$85,000	Development of a Brief Integrative Psychotherapy for PTSD Related to Childhood Sexual Abuse	WOMEN * STRESS DISORDERS, POST-TRAUMATIC * PSYCHOTHERAPY * CHILD ABUSE, SEXUAL * *
662 San Francisco, CA	Neylan, Thomas	9135 Natl Inst on Mental Health	$56,379	Sleep & Arousal Disturbances in PTSD	SLEEP * CLINICAL MEDICINE * AROUSAL * * *
608 Manchester, NH	Orr, Scott	9135 Natl Inst on Mental Health	$275,102	Prospective Psychophysiologic Study of Risk for PTSD	STRESS DISORDERS, POST-TRAUMATIC * PSYCHOPHYSIOLOGY * PROSPECTIVE STUDIES * * *
523 Boston, MA	Street, Amy	9135 Natl Inst on Mental Health	$3,000	IRB# 1431: Risk Factors for Stressful Events	STRESS, PSYCHOLOGICAL * STRESS DISORDERS, POST-TRAUMATIC * RISK FACTORS * * *
640 Palo Alto, CA	Woodward, Steven	9135 Natl Inst on Mental Health	$3,544	Sleep and Startle in PTSD-Discordant Monozygotic Twins	TWINS, MONOZYGOTIC * STRESS DISORDERS, POST-TRAUMATIC * STARTLE REACTION * SLEEP * *
526 Bronx, NY	Yehuda, Rachel	9135 Natl Inst on Mental Health	$179,584	Biology of Risk and PTSD in Holocaust Survivor Offspring	STRESS DISORDERS, POST-TRAUMATIC * COGNITION * CATECHOLAMINES * * *
526 Bronx, NY	Yehuda, Rachel	9135 Natl Inst on Mental Health	$80,174	Prospective Psychophysiologic Study of Risk for PTSD	STRESS DISORDERS, POST-TRAUMATIC * SALIVA * PSYCHOPHYSIOLOGY * * *
526 Bronx, NY	Yehuda, Rachel	9135 Natl Inst on Mental Health	$42,870	Prospective neurobiological Study of PTSD	STRESS DISORDERS, POST-TRAUMATIC * SALIVA * BLOOD * * *
526 Bronx, NY	Yehuda, Rachel	9135 Natl Inst on Mental Health	$175,080	The Relationship between Biological and Psychological Correlates of PTSD	STRESS DISORDERS, POST-TRAUMATIC * HYDROCORTISONE * CATECHOLAMINES * * *
523 Boston, MA	Zimering, Rose	9135 Natl Inst on Mental Health	$97,250	Assessing Secondary Trauma in Disaster Relief Clinicians	STRESS DISORDERS, POST-TRAUMATIC * PSYCHOLOGY * DISASTERS * * *
			$5,041,455		
508 Decatur, GA	Bremner, James	9203 Dept of Defense	$172,033	The Effects of Captivity Stress on Cardiovascular Disease	STRESS DISORDERS, POST-TRAUMATIC * ISCHEMIA * CARDIOVASCULAR DISEASES * * *
506 Ann Arbor, MI	Fig, Lorraine	9203 Dept of Defense	$33,857	Limbic Blood Flow & Opiate Receptor PET in Posttraumatic Stress Disorder	STRESS DISORDERS, POST-TRAUMATIC * RECEPTORS, OPIOID * RADIONUCLIDE IMAGING * NARCOTICS * *
523 Boston, MA	Litz, Brett	9203 Dept of Defense	$1,378	The Effects of Psychological Debriefing on Soldiers Deployed on a Peacekeeping Mission	STRESS DISORDERS, POST-TRAUMATIC * HEART RATE * DRUG THERAPY * * *
689 West Haven, CT	Morgan, III, Charles	9203 Dept of Defense	$69,500	Pharmacologic Modulation of Baseline and Fear Potentiated Startle in Humans	STRESS DISORDERS, POST-TRAUMATIC * STARTLE REACTION * PHARMACY * FEAR * *
561 East Orange, NJ	Servatius, Richard	9203 Dept of Defense	$116,793	Traumatic Experiences Enhance Cue-Dependent Learing	STRESS DISORDERS, POST-TRAUMATIC * REPRESSION-SENSITIZATION * CONDITIONING, CLASSICAL * * *
640 Palo Alto, CA	Woodward, Steven	9203 Dept of Defense	$8,814	Effects of Combat Stress on the Structure and Function of the Hippocampus	STRESS DISORDERS, POST-TRAUMATIC * PSYCHOPHYSIOLOGY * MAGNETIC RESONANCE IMAGING * HIPPOCAMPUS * *

Attachment B
VA Funded PTSD Projects - FY 2003

Station	Investigator	FundDesc	FundingExp	Title	MeSH
405 White River Junction, VT	Bursztajn, Sherry	9299 Other Federal Government Agency	$24,392	Role of Fear Conditioning on Neurogenesis	STRESS DISORDERS, POST-TRAUMATIC * RECEPTORS, GLUTAMATE * MICE, TRANSGENIC * FEAR * CELL DIVISION * AMYGDALA
629 New Orleans, LA	Vasterling, Jennifer	9299 Other Federal Government Agency	$45,127	Cognitive Biases in Comorbid Depression and PTSD: An fMRI Study	STRESS DISORDERS, POST-TRAUMATIC * MAGNETIC RESONANCE IMAGING * DEPRESSION * * *
			$471,894		
662 San Francisco, CA	Marmar, Charles	9301 Affiliated University	$29,226	Donation Account	STRESS DISORDERS, POST-TRAUMATIC * MAGNETIC RESONANCE IMAGING * BIOLOGICAL PSYCHIATRY * * *
663 Seattle, WA	Simpson, Tracy	9301 Affiliated University	$1,532	Evaluation of a New Prospective Methodology for Assessing the Contribution of PTSD to Alcohol Craving and Relapse	SUBSTANCE-RELATED DISORDERS * STRESS DISORDERS, POST-TRAUMATIC * RECURRENCE * ETHANOL * *
528 Buffalo, NY	Julian, Terri	9360 VA Medical Care Supported Mgmt. Studies	$2,060	Psychological Strengths in Vietnam War Veterans with PTSD	VIETNAM * STRESS DISORDERS, POST-TRAUMATIC * PSYCHOLOGY, CLINICAL * * *
662 San Francisco, CA	Marmar, Charles	9360 VA Medical Care Supported Mgmt. Studies	$327,302	MIRECC: Open Trial of Fluvoxamine Treatment for Female Veterans with Posttraumatic Disorder	WOMEN * STRESS DISORDERS, POST-TRAUMATIC * MENTAL DISORDERS * FLUVOXAMINE * CLINICAL TRIALS *
640 Palo Alto, CA	Yesavage, Jerome	9360 VA Medical Care Supported Mgmt. Studies	$1,432,860	Mental Illness Research, Education and Clinical Center (MIRECC)	STRESS DISORDERS, POST-TRAUMATIC * PSYCHOTHERAPY * MENTAL DISORDERS * GUANFACINE * FLUVOXAMINE *
618 Minneapolis, MN	Arbisi, Paul	9399 Other Government or Academic	$3,087	Validation of the F(p) Scale and Investigation of Response Set Strategies	STRESS DISORDERS, POST-TRAUMATIC * REPRODUCIBILITY OF RESULTS * MALINGERING * * *
618 Minneapolis, MN	Arbisi, Paul	9399 Other Government or Academic	$3,087	Development of a Revised PTSD Scale for the MMPI-2	STRESS DISORDERS, POST-TRAUMATIC * SELF ASSESSMENT (PSYCHOLOGY) * MMPI * * *
642 Philadelphia, PA	Cook, Joan	9399 Other Government or Academic	$23,888	Feasibility of Delivering the Seeking Safety Group Therapy for Post-Traumatic Stress Disorder & Substance Abuse to Homeless Male Veterans	SUBSTANCE-RELATED DISORDERS * STRESS DISORDERS, POST-TRAUMATIC * HOMELESS PERSONS * * *
660 Salt Lake City, UT	Overall, James	9399 Other Government or Academic	$50	An Evaluation of Equine-Facilitated Psychotherapy of Post-Traumatic Stress Disorder (PTSD)	STRESS DISORDERS, POST-TRAUMATIC * PSYCHOTHERAPY * OCCUPATIONAL THERAPY * * *
			$1,823,092		
679 Tuscaloosa, AL	Davis, Lori	9703 Abbott	$3,752	Retrospective Chart Review of the Effects of Divalproex in the Treatment of Posttraumatic Stress Disorder	VALPROIC ACID * STRESS DISORDERS, POST-TRAUMATIC * ANTICONVULSANTS * * *
679 Tuscaloosa, AL	Davis, Lori	9703 Abbott	$42,924	Maintenance Phase Treatment with Divalproex for PTSD	STRESS DISORDERS, POST-TRAUMATIC * MAINTENANCE * GAMMA-AMINOBUTYRIC ACID * * *
534 Charleston, SC	Hamner, Mark	9717 Bristol-Meyers Squibb	$1,206	An Open Label Assessment of Aripiprazole in the Treatment of PTSD	STRESS DISORDERS, POST-TRAUMATIC * DOPAMINE * ANTIPSYCHOTIC AGENTS * * *
534 Charleston, SC	Hamner, Mark	9731 Eli Lilly	$26,669	Olanzapine Treatment of Psychotic Features Associated with Posttraumatic Stress Disorder	STRESS DISORDERS, POST-TRAUMATIC * PSYCHOTIC DISORDERS * ANXIETY * * *
674 Temple, TX	Young, Keith	9731 Eli Lilly	$6,726	Zyprexa Treatment of Post-Traumatic Stress Disorder	STRESS DISORDERS, POST-TRAUMATIC * DRUG THERAPY * CLINICAL TRIALS * * *
558 Durham, NC	Beckham, Jean	9738 Glaxo	$80,635	Preliminary Study of Bupropion for Social and Occupational Dysfunction, Symptom Reduction and Smoking Cessation in PTSD	STRESS DISORDERS, POST-TRAUMATIC * SMOKING CESSATION * BUPROPION * * *

Attachment B
VA Funded PTSD Projects - FY 2003

Station	Investigator	FundDesc	FundingExp	Title	MeSH
691 West Los Angeles, CA	Bartzokis, George	9746 Janssen	$74,067	A Double-Blind, Placebo-Controlled Study of Risperidone for the Treatment of Post Traumatic Stress Disorder (PTSD)	STRESS DISORDERS, POST-TRAUMATIC * RISPERIDONE * CLINICAL TRIALS * ANXIETY DISORDERS * *
546 Miami, FL	David, Daniella	9746 Janssen	$4,012	Risperidone Treatment for Chronic Post Traumatic Stress Disorder	STRESS DISORDERS, POST-TRAUMATIC * RISPERIDONE * PSYCHOMOTOR AGITATION * HALLUCINATIONS * *
679 Tuscaloosa, AL	Davis, Lori	9746 Janssen	$48,042	Topiramate for the Treatment of Ptsd	STRESS DISORDERS, POST-TRAUMATIC * DRUG THERAPY * ANTICONVULSANTS * * *
534 Charleston, SC	Hamner, Mark	9746 Janssen	$17,252	An Open Label Assessment of Escitalopram in the Treatment of PTSD	STRESS DISORDERS, POST-TRAUMATIC * SEROTONIN UPTAKE INHIBITORS * CLINICAL TRIALS * ANTIDEPRESSIVE AGENTS * *
689 West Haven, CT	Rasmusson, Ann	9746 Janssen	$678	Effectiveness of Risperidone in the Treatment of PTSD - Part I: Treatment Trial	STRESS DISORDERS, POST-TRAUMATIC * RISPERIDONE * DRUG THERAPY * * *
640 Palo Alto, CA	Carlson, Eve	9770 Ortho	$360	Topiramate in the Treatment of Symptoms of Chronic PTSD	STRESS DISORDERS, POST-TRAUMATIC * ANTICONVULSANTS * AGGRESSION * * *
640 Palo Alto, CA	Lindley, Steven	9770 Ortho	$5,110	Topiramate in the Treatment of Symptoms of Chronic PTSD	STRESS DISORDERS, POST-TRAUMATIC * ANTICONVULSANTS * AGGRESSION * * *
679 Tuscaloosa, AL	Davis, Lori	9773 Parke-Davis	$14,740	Serotonin Function in Post-Traumatic Stress Disorder	STRESS DISORDERS, POST-TRAUMATIC * SEROTONIN * ANXIETY DISORDERS * * *
506 Ann Arbor, MI	Liberzon, Israel	9775 Pfizer	$19,742	Sertaline Feasibility Trial in Trauma Surgery Patients for PTSD and Depression	STRESS DISORDERS, POST-TRAUMATIC * PREVENTIVE MEDICINE * DEPRESSION * * *
636 Omaha, NE	Petty, Frederick	9775 Pfizer	$24,335	Zoloft (Sertraline) Therapy for Post-traumatic Stress Disorder (PTSD)	STRESS DISORDERS, POST-TRAUMATIC * DEPRESSION * ANXIETY * * *
526 Bronx, NY	Yehuda, Rachel	9782 R.W. Johnson Pharm	$23,438	The Effect of Topamax on the Human Glucocorticoid receptor in PTSD	STRESS DISORDERS, POST-TRAUMATIC * NEUROENDOCRINOLOGY * GLUCOCORTICOIDS * * *
618 Minneapolis, MN	Dieperink, Eric	9784 Schering	$3,061	The Effect of PEG Interferon and Ribaviron for Patients with Hepatitis C on PTSD Symptoms	STRESS DISORDERS, POST-TRAUMATIC * INTERFERONS * HEPATITIS C * DEPRESSION * *
501 Albuquerque, NM	Escalona, Rodrigo	9797 Wyeth-Ayerst	$28,527	A D-B, Randomized, P-C, 3-Month Clinical Trial of Venlafaxine ER and Sertraline in the Treatment of Post Traumatic Stress Disorder	STRESS DISORDERS, POST-TRAUMATIC * DRUG THERAPY * CLINICAL TRIALS * * *
534 Charleston, SC	Hamner, Mark	9797 Wyeth-Ayerst	$18,018	A Double-Blind, Randomized, Placebo Controlled 3-Month Clinical Trial of Venlafaxine ER and Sertraline in the Treatment of PTSD	TREATMENT OUTCOME * STRESS DISORDERS, POST-TRAUMATIC * CLINICAL TRIALS * * *
506 Ann Arbor, MI	Liberzon, Israel	9797 Wyeth-Ayerst	$575	A Double-Blind, Randomized, Placebo-controlled, 3-Month Clinical Trial of Venlafzaxine ER and Sertraline in the Treatment of PTSD	STRESS DISORDERS, POST-TRAUMATIC * PSYCHOLOGY, CLINICAL * CLINICAL TRIALS * * *
640 Palo Alto, CA	Lindley, Steven	9797 Wyeth-Ayerst	$8,193	A Double Blind, Ramdomized, Placebo-Controlled, 3 Month Clinicl Trial of Venlafaxine ER and Setraline in the Treatment of PTSD	STRESS DISORDERS, POST-TRAUMATIC * DEPRESSION * ANXIETY DISORDERS * * *
618 Minneapolis, MN	Westermeyer, Joseph	9797 Wyeth-Ayerst	$11,039	A Double-Blind Randomized Placebo-Controlled 3 Month Clinical Trial of Venlafaxine ER & Sertraline in Treatment of PTSD	STRESS DISORDERS, POST-TRAUMATIC * SEROTONIN * CLINICAL TRIALS * * *
501 Albuquerque, NM	Canive, Jose	9798 Zeneca	$9,781	A Randomized, Placebo-Controlled Trial of Quetiapine (Seroquel) Monotherapy in the Treatment of PTSD	STRESS DISORDERS, POST-TRAUMATIC * PSYCHIATRY * CLINICAL TRIALS * * *

Attachment B
VA Funded PTSD Projects - FY 2003

Station	Investigator	FundDesc	FundingExp	Title	MeSH
607 Madison, WI	Ahearn, Eileen	9799 Other Private Proprietary Company	$2,000	Quetiapine as an Adjunctive Treatment for Patients with PTSD Refractory to SSRIs: An Open-Label 8 Week Trial	STRESS DISORDERS, POST-TRAUMATIC * DRUG THERAPY * CLINICAL TRIALS * * *
539 Cincinnati, OH	Baker, Dewleen	9799 Other Private Proprietary Company	$53,438	Open Label, Flexible Dose, Randomized, 12 Wk Clinical Trial of the Safety & Efficacy of Escitalopram in Comparison w/Sertraline in Tx of PTSD	STRESS DISORDERS, POST-TRAUMATIC * DOSE-RESPONSE RELATIONSHIP, DRUG * CLINICAL TRIALS * * *
539 Cincinnati, OH	Baker, Dewleen	9799 Other Private Proprietary Company	$12,313	12 Wk Randomized, DB, PC, PG, Flex-Dos Study to Eval Efficacy & Safety of Gabitril @ Dosages up to 16mg/day in Tx of Chronic PTSD in Adults	TREATMENT OUTCOME * STRESS DISORDERS, POST-TRAUMATIC * CLINICAL TRIALS * * *
671 San Antonio, TX	Faber, Raymond	9799 Other Private Proprietary Company	$5,603	A Pilot Study of VoiceTherapy in Schizophrenia and Post-Traumatic Stress Disorder	VOICE * STRESS DISORDERS, POST-TRAUMATIC * SCHIZOPHRENIA * * *
534 Charleston, SC	Hamner, Mark	9799 Other Private Proprietary Company	$105,354	A Randomized, Placebo-Controlled Trial of Quetiapine (Seroquel) Monotherapy in the Treatment of PTSD	STRESS DISORDERS, POST-TRAUMATIC * PSYCHOTIC DISORDERS * CLINICAL TRIALS * * *
664 San Diego, CA	Lang, Ariel	9799 Other Private Proprietary Company	$10,474	Randomized Trial of Paroxetine-CR for the Treatment of Patients with Postraumatic Stress Disorder (PTSD) Remaining Symptomatic after Initial	STRESS DISORDERS, POST-TRAUMATIC * PAROXETINE * CLINICAL TRIALS * * *
506 Ann Arbor, MI	Liberzon, Israel	9799 Other Private Proprietary Company	$41,613	Topiramate in Animal Model of PTSD	STRESS DISORDERS, POST-TRAUMATIC * STARTLE REACTION * GLUCOCORTICOIDS * DISEASE MODELS, ANIMAL * ANTICONVULSANTS *
662 San Francisco, CA	Neylan, Thomas	9799 Other Private Proprietary Company	$48,000	Open Trial of Escitalopram Treatment for Male Subjects with Postraumatic Stress Disorder	STRESS DISORDERS, POST-TRAUMATIC * MEN * DRUG THERAPY * * *
541 Cleveland, OH	Semple, William	9799 Other Private Proprietary Company	$1,189	Brain and Attention in Substance Abusers with PTSD	TOMOGRAPHY * SUBSTANCE-RELATED DISORDERS * STRESS DISORDERS, POST-TRAUMATIC * BRAIN * *
			$752,866		
660 Salt Lake City, UT	Bennett, Pamela	9895 Va Private Research Corporation	$3,686	Genetic Risk Factors and Altered Brain Structure in PTSD	STRESS DISORDERS, POST-TRAUMATIC * RISK FACTORS * RECEPTORS, OPIOID * GENETICS * BRAIN *
578 Hines, IL	Crayton, John	9895 Va Private Research Corporation	$2,849	National Health Survey of Persian Gulf Veterans and Their Families	STRESS DISORDERS, POST-TRAUMATIC * PERSIAN GULF SYNDROME * HEALTH STATUS * FATIGUE SYNDROME, CHRONIC * CROSS-SECTIONAL STUDIES *
663 Seattle, WA	Boyko, Edward	9899 Other Voluntary Agency\Foundation	$198,801	The Vietnam Era Twin (VET) Registry: History, Organization and Operation	VIETNAM * TWINS * STRESS DISORDERS, POST-TRAUMATIC * MENTAL HEALTH * GENETICS *
459 Honolulu, HI	Bracha, H. Stefan	9899 Other Voluntary Agency\Foundation	$6,375	Validating a Laboratory Procedures for Estimating Early Deleterious Life Experiences	STRESS DISORDERS, POST-TRAUMATIC * NEUROBIOLOGY * AUTONOMIC NERVOUS SYSTEM * * *
618 Minneapolis, MN	Engdahl, Brian	9899 Other Voluntary Agency\Foundation	$1,756	Posttraumatic Growth Among Former Prisoners of War	TRAUMATOLOGY * STRESS DISORDERS, POST-TRAUMATIC * PRISONERS * * *
570 Fresno, CA	Hierholzer, Robert	9899 Other Voluntary Agency\Foundation	$20,251	Care for the Soul: The Role of Divine and Human Love in Adjustment to Military Trauma	STRESS DISORDERS, POST-TRAUMATIC * NEOPLASMS, POST-TRAUMATIC * LOVE * * *

Attachment B
VA Funded PTSD Projects - FY 2003

Station	Investigator	FundDesc	FundingExp	Title	MeSH
405 White River Junction, VT	Monson, Candice	9899 Other Voluntary Agency\Foundation	$3,291	A Pilot Study of Cognitive-Behavioral Conjoint Treatment for Post-Traumatic Stress Disorder	TREATMENT OUTCOME * STRESS DISORDERS, POST-TRAUMATIC * PSYCHOTHERAPY * * *
629 New Orleans, LA	Sautter, Frederic	9899 Other Voluntary Agency\Foundation	$40,000	Biology of Psychosis in Posttraumatic Stress Disorder (PTSD)	STRESS DISORDERS, POST-TRAUMATIC * PSYCHOTIC DISORDERS * CLINICAL TRIALS * * *
618 Minneapolis, MN	Westermeyer, Joseph	9899 Other Voluntary Agency\Foundation	$2,277	Actigraphy in the Study of Sleep Symptoms Assoc w/PTSD: Use of Sleep Actigraphy to Assess Insomnia in Posttrauma Patients	STRESS DISORDERS, POST-TRAUMATIC * SLEEP INITIATION AND MAINTENANCE DISORDERS * CLINICAL TRIALS * * *
			$279,286		
			$12,562,571		

Under Secretary for Health's Response to the Recommendations of the Special Committee on PTSD: Appendix A

This section is in response to recommendations/objectives that were not closed by the PTSD Special Committee in Attachment A of its 2004 report.

Domain 3- Optimizing the continuum of care for PTSD in VA

Objectives:

1. A Continuity Implementation Planning Committee composed of representatives of Veterans Health Administration (VHA), Readjustment Counseling Service (RCS), Veterans Benefits Administration (VBA), Information Resource Management Service (IRMS), and the General Counsel's Office, should be established for the purpose of developing appropriate access to clinical data across VA's PTSD continuum of care.

2. The Veterans Integrated Service Networks (VISNs) and RCS will provide a list of names of coordinators or members of their respective coordination groups for membership on this new committee.

Response: Concur in concept. As noted in the comments section of this domain, the Committee recommends that these functions be addressed by a Joint VA/DoD Council on Post-Deployment Mental Health. VHA will discuss the possibility of creating such a council with our DoD partners. A VA/DoD Joint Council on Post-Deployment Mental Health could coordinate activities in relation to mental health issues and their integration with other health care for returning veterans, and joint educational and research projects related to post-deployment issues. The Council could serve as a subcommittee reporting to an existing VA/ DoD group such as the Post Deployment Work Group.

A list of VISN and RCS field coordinators will be provided to the Committee within 60 days of this Report's release.

No Domain cited.

Recommendation 19: Increased access to care is needed. This can be facilitated through the continued expansion of Vet Centers, RCS outstations, CBOCs (with specialized PTSD services), and Telemedicine services into under-served geographic areas.

Objective: The Committee requests a list of expansion sites currently under consideration.

Response: Section 108 of Public Law 108-170 authorized $5 million to expand specialized services for PTSD. These funds will be made available for three fiscal years. When expanded sites are selected, a listing will be posted on the Mental Health web page. It is expected that site selection will be completed by the end of the present fiscal year.

No Domain cited.

<u>Recommendation 20</u>: Veterans who have suffered sexual trauma while on active military duty have been granted access to counseling and treatment for their post-traumatic medical needs regardless of their income status (38 USC 1720D). The same level of access should be applied to all veterans seeking counseling and treatment stemming from psychological trauma during active military duty.

<u>Objective</u>: Propose legislative language that will grant cost-free PTSD treatment for all veterans with PTSD-related to military service.

Response: This recommendation remains under consideration within VHA.

No Domain cited.

<u>Recommendation 21</u>: VA should extend its effort to monitor the productivity and quality of specialized PTSD services across the PTSD continuum of care, including measures of functionality, quality of life and social support.

<u>Objective</u>: The Committee requests a progress report on the monitoring plan as identified above. This report should specify a timetable and the resources required for full implementation.

Response: As noted in the Committee's comments, the National Center for PTSD (NCPTSD) is piloting a measure of functionality, which is expected to include a valid scale for quality of life and social support. Further, the Committee has been working with the NCPTSD on this measure and plans to follow its progress. Further action does not appear to be indicated.

No Domain cited.

Recommendation 23: VA must expand the focus of PTSD treatment, to include family assessment and intervention, in order to help protect veterans and their families from the shattering effects of PTSD. In doing so, VA is following the mission set by Abraham Lincoln who understood that veterans services are never just about the veteran, but his/her spouse must be considered as well.

Objective: The Committee requests a report outlining VA plans to provide services to the families of veterans suffering from PTSD.

Response: The Committee made a recommendation both last year and this year regarding the addition of a family therapist to each Vet Center. A response to that recommendation can be found in the appropriate section of this document. The Seamless Transition Task Force and Readjustment Counseling Service have both been active in promoting services for families of OEF/OIF troops. A report of these activities will be provided to the Committee within 60 days of the release of this Report.

No Domain cited.

Recommendation 26: VA should improve Educational Collaboration with the Department of Defense.

Objective: The Committee requests a summary of VA-DoD collaborations to date and of existing plans for improving educational collaboration on traumatic stress between the two agencies.

Response: In addition to the Clinical Practice Guideline mentioned in the Comments section, educational collaborations between VA/DoD over the past year include The Iraqi Clinician War Guide. Two additional satellite broadcasts are planned to occur before the end of the current fiscal year. One of these broadcasts will focus on returning new combat veterans and the second on suicide prevention in the community. The proposed VA/DoD Council on Post-Deployment Mental Health would also address educational projects as well.

Domain 6. Funding for Research.

Recommendations 27-28: Research Service should work with the Special Committee to compare and evaluate the process for funding PTSD projects in order to establish appropriate research goals and research funding targets. Consideration should be given to identifying PTSD as a Designated Research Area, with a subcommittee within VA Research and Development that specifically reviews PTSD-related research.

Objectives: The Committee requests a summary of discussions between MHSHG and Research Service to date, as they pertain to Recommendations 27 and 28. Further, in order to allow the Committee to determine the sufficiency of funding for PTSD research, we also request that MHSHG obtain from Research Service the following information for the last five fiscal years:

1. **The number of VA-funded research projects in which PTSD is a primary focus.**
2. **The total amount of funding for these projects on an annual basis.**
3. **The number of VA-funded research projects and amount of funding for all other mental health research projects where PTSD is not a primary focus.**
4. **A list of specific projects that were funded and projects that were not funded within mental health, for both PTSD-related and non-PTSD related areas.**

We request that Research Service continue to provide the committee with the aforementioned data on an annual basis either directly or through MHSH in future years.

Response: These recommendations have been stated and reframed in Recommendation number 7 for the 2003 report. A response to the revised recommendation can be found there. In addition, a listing of research projects funded in FY 03 is appended to the present report.

No Domain cited.

Recommendation 29: VA should increase funding for post-doctoral research positions in PTSD (VA recently developed a clinical post-doctoral program for specialization in PTSD; however, development of a research emphasis program would ensure the continued scientific expertise of VA researchers).

Objective: The Committee requests that:

1. The proposed meeting between MHSHG, Office of Academic Affairs (OAA), and NCPTSD be convened to take up this issue and that we receive a report of their progress.
2. The Committee receives a report of the number of Mental Illness Research Education Clinical Center (MIRECC) post-doctoral fellows who identified PTSD as a primary research focus (source: MIRECC Hub Site at Palo Alto, VA Medical Center).
3. MHSHG and OAA explore the promotion and funding of PTSD Research fellowships outside of the MIRECCs mechanism as well.

Response: An Request for Proposals (RFP) for two new MIRECCs is in the final stages of review. It is possible that additional postdoctoral opportunities will be forthcoming from this initiative but the results are not yet available. A meeting with OAA, the NCPTSD and MIRECC fellowship Hub Site leadership on PTSD fellowships will take place within 90 days of the release of this Report. This timeline will ensure that the new MIRECC designations will be approved by the time of the meeting.

No Domain cited.

Recommendation 30: VA should expand funding to increase the number of MIRECCs with special solicitations for MIRECCs aimed at PTSD-specific research including psychobiological effects of trauma across the life span and/or a MIRECC specifically focused on collaboration with DoD on PTSD. Such MIRECC proposals should be reviewed with this Committee.

Objective: The Committee requests a summary of the stated research emphasis areas of pending MIRECC proposals, including letters of interest recently solicited in anticipation of new MIRECC funding.

Response: An RFP for two new MIRECCs is in the final stages of review. This review process is confidential and the information requested is not yet available for release. A formal announcement will be forthcoming when the final selections have been made.

Domain 7: Goals for collaboration, coordination and expansion of PTSD research.

Recommendations 31-32: The Committee should work with The National Center for PTSD, MIRECCs, and Health Services Centers of Excellence to enhance communication, collaboration, and coordination in PTSD research across VA, and between VA and other Federal and non-Federal agencies. The Committee should work with The National Center for PTSD, MIRECCs, Health Services Centers of Excellence and other Federal and non-Federal agencies to enhance communication, collaboration and coordination on PTSD research goals.

Objectives: In order to meet the endorsed recommendation that PTSD researchers in the VA improve communication and collaboration, the Committee requests that the Under Secretary convene a VA Traumatic Stress Research Summit. This meeting, to be organized by the NC-PTSD, will provide senior researchers with an opportunity to come together and will encourage new, more junior investigators to specialize in PTSD research. The rationale for the Research Summit and suggestions for its organization are as follows:

Response: An Request for Proposals (RFP) for two new MIRECCs is in the final stages of review. It is possible that additional postdoctoral opportunities will be forthcoming from this initiative but the results are not yet available. A meeting with OAA, the NCPTSD and MIRECC fellowship Hub Site leadership on PTSD fellowships will take place within 90 days of the release of this Report. This timeline will ensure that the new MIRECC designations will be approved by the time of the meeting.

No Domain cited.

Recommendation 30: VA should expand funding to increase the number of MIRECCs with special solicitations for MIRECCs aimed at PTSD-specific research including psychobiological effects of trauma across the life span and/or a MIRECC specifically focused on collaboration with DoD on PTSD. Such MIRECC proposals should be reviewed with this Committee.

Objective: The Committee requests a summary of the stated research emphasis areas of pending MIRECC proposals, including letters of interest recently solicited in anticipation of new MIRECC funding.

Response: An RFP for two new MIRECCs is in the final stages of review. This review process is confidential and the information requested is not yet available for release. A formal announcement will be forthcoming when the final selections have been made.

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Objectives: In order to meet the endorsed recommendation that PTSD researchers in the VA improve communication and collaboration, the Committee requests that the Under Secretary convene a VA Traumatic Stress Research Summit. This meeting, to be organized by the NC-PTSD, will provide senior researchers with an opportunity to come together and will encourage new, more junior investigators to specialize in PTSD research. The rationale for the Research Summit and suggestions for its organization are as follows:

1. The PTSD Summit would provide VA with an opportunity to educate staff throughout VA, as well as from other branches of the government (including members of Congress and their staffs), about the consequences of traumatic stress and about VA's unique expertise in this critically important area. It would provide an excellent meeting place for VA staff to interact with experts from DoD, other Federal and Non-Federal agencies including Veterans Service Organizations (VSOs), the American Red Cross, the Salvation Army, and other important stakeholders.
2. The VA PTSD summit could be an excellent venue for stimulating collaboration between the NC-PTSD and the National Center for War-Related Illnesses.
3. The Committee will work with the National Center for PTSD and MIRECCs to identify themes for future Research Summits.

The Committee further recommends that VA provide travel funds to enable junior investigators to attend. NC-PTSD should develop a plan to set up mentoring relationships between junior and senior investigators attending the Summit.

Response: The Committee suggests that this recommendation be implemented through the Joint DoD/VA Council on Post Deployment, which is proposed in Recommendation 2A of the 2004 report. The Summit could be held within 90 days of the establishment of the Council.

DOMAIN 8: Assuring equal access and efficient service for veterans filing claims for service connection for PTSD across VA.

<u>Recommendations 33-34</u>: VBA should collect appropriate data on grants/denials and percentage of service connection for PTSD evaluations by each Regional Office. VA should closely monitor and seek to develop new policy and training initiatives should the data demonstrate significant disparity across the system. VBA should, if feasible, gather office-by-office data about variability in: (a) time from date of filing a claim to date of service connection; and (b) rates of service connection across different populations (including different stressor categories, genders, and ethnic groups).

<u>Objectives:</u> The Committee recommends that a meeting take place between Committee members and representatives of VBA for the purpose of developing a set of useful assessment measures. These measures might include information about: (a) the total number of disability claims filed; (b) the number of claims specifically filed for PTSD; (c) the number (and percent of disability awarded) of claims approved for the general veteran population and for PTSD, respectively; (d) the percentage of claims filed for PTSD in which the stressor was confirmed; (e) the percentage of

claimants for whom the diagnosis of PTSD was confirmed; (f) the number and percentage of PTSD claims that were appealed; (g) the number of appealed claims for PTSD that were overturned; and (h) the percent increase in disability awarded in those successfully appealed claims.

The Committee would also be interested in information about the average time necessary to process PTSD claims and whether it differs from the average time necessary to process other claims. Providing a breakdown of the aforementioned data by gender and ethnicity is highly desirable. Whenever possible, data should be examined at the national level and compared between individual Regional Offices.

Response: The MHSHG and VBA will be directed to schedule a meeting within 30 days of this report's release to discuss the matters raised by Recommendations 33-35. The Committee will be informed of this meeting's outcome and plans to obtain the data requested within ninety days of the release of this report. The Committee is commended for its work in the area of Compensation and Pension Examinations and its ongoing work to consider OIE/OEF combat veterans in this context.

No Domain cited.

<u>Recommendation 35</u>: VA should support a research study of the quality of PTSD Compensation and Pension (C&P) exams. Any review of exam quality should include exams done by VA staff, by QTC contract examiners, and by independent fee-basis examiners hired by local medical facilities.

<u>Objective</u>: The Committee requests a report on VBA's assessments in this area (as referred to in the Under Secretary's response to this Recommendation) and a report from VBA on the feasibility of pursuing further exploration of the quality of PTSD examinations. A "Best Practices" guideline for conducting PTSD C&P examinations will be released in by fourth quarter FY 2002, reflecting the combined efforts of the National Center for PTSD, the Northwest MIRECC, and VBA. The Committee requests that VBA, MHSHG, and Research Service develop a preliminary plan, in collaboration with the architects of this guideline, for its implementation and testing through research initiatives. Specifically, we recommend that Research Service support proposals aimed at studying: (a) the current status and quality of PTSD disability evaluations; and (b) the implementation of standardized, evidence-based practices in the PTSD assessment process.

Response: See response to Recommendations 33-34.